Salisbury NHS
NHS Foundation Trust

Annual Report and Accounts 2011/2012

Salisbury NHS Foundation Trust

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Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) of the National Health Service Act 2006

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Message from the Chairman

This has been another challenging year, yet despite the economic situation we have continued to maintain the high standards that we have set ourselves and make real improvements in facilities and services.

This is essential for existing patients who use our general and specialist services, and for many others throughout Wiltshire, Dorset and Hampshire who are now selecting Salisbury District Hospital as their hospital of choice when deciding where to have their treatment.

It is vital for all our patients that we focus on the areas that matter most – the delivery of excellent safe care, together with prompt access to our services.

This year we continued to maintain good waiting times for treatment and put in place a number of changes that help to get people home sooner to their family and friends when they are medically fit to do so. We have also worked carefully with GPs to provide them with additional support and expert advice. This is so that patients who need urgent assessment and further tests and treatment for existing conditions can be seen promptly in a medical or surgical admissions unit. In some cases this direct contact between the GP and the specialist can avoid actual admission to hospital.

Feedback from patients on the quality of care they have received is essential for us if we are to address any deficiencies. We have continued to receive positive comments through letters, our customer care department, national patient surveys and our own 'real time' feedback, which is gathered daily from patients on wards and in clinics. Where our patients have raised concerns we are determined to address the specific issues and we have continued to use these comments constructively to make changes where necessary.

Of course assessments from independent bodies also give us an indication of how we are performing and following a routine unannounced inspection by the Care Quality Commission (CQC) we received a positive report. The CQC found that we meet all essential quality and safety standards. Patients also felt that their rights to privacy, dignity and respect were fully promoted. Adequate nutrition and hydration, good food choices and hospital cleanliness were also examples of other positive points they identified.

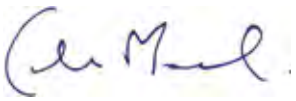
We have made real progress on safe, quality care and this will continue to be our number one priority. To do this, we must continue to make best use of new technology and ensure that our staff have the skills that they need to develop within a culture of innovation and improvement. Examples of this can be seen throughout this year's annual report and I want to use this opportunity to thank our staff again for their professionalism and commitment to their patients. There is no doubt that with greater financial pressures and the number of patients we see, our staff will continue to make a significant contribution to the quality of care that we all recognise and appreciate.

Our local community continues to play a key role in the development of the hospital and its services through the very active involvement of our Governors and members and the wide range of fundraising activities that are carried out principally in conjunction with the Stars Appeal. Local people played a key role in the new Children's Unit which opened during the year and they are continuing to support other developments such as a new Neonatal Intensive Care Unit and family accommodation for parents who need to stay close to their newborn babies. Work has already started on this project, which will be completed later in the year. We also enjoy significant support from other charitable sources such as the Salisbury League of Friends and the Southern Spinal Injuries Trust. I cannot thank enough all those who have helped the hospital throughout the year. Their support and generosity is much appreciated.

This is just a small selection of the outstanding work that has taken place throughout the year, and there is more within the report. Clearly there are challenges ahead as we look carefully at how we can provide more effective and efficient services for our patients. We will continue to monitor the new NHS Reforms, and relationships with our key stakeholders will be even more integral to our future. This includes our existing commissioners at Primary Care Trusts and the new Clinical Commissioning Groups, GPs, social and community care in Wiltshire, Hampshire and Dorset, neighbouring NHS Trusts and our principal regulators at Monitor and the Care Quality Commission.

Above all else we will continue to maintain our high standards and the good quality of care that is such a key factor for patients at Salisbury District Hospital. This would not be possible without the dedication and professionalism of our staff who deserve our special thanks.

Finally, on behalf of the Board I wish to recognise the considerable contribution that Peter Hill has made as Interim Chief Executive over the last 16 months and wish him well in his new role here as Chief Operating Officer. I also want to welcome Caspar Ridley who has now joined us as our new Chief Executive.



Luke March, Chairman
25 May 2012

Values and Beliefs

All strategic planning is underpinned by a number of values and beliefs. These were developed in conjunction with staff and are used in their day to day work with patients, colleagues and stakeholders.

Patients
We will put the safety and wellbeing of patients at the forefront of everything we do

Respect
We will treat each individual with respect

Culture
We will be welcoming, friendly and helpful

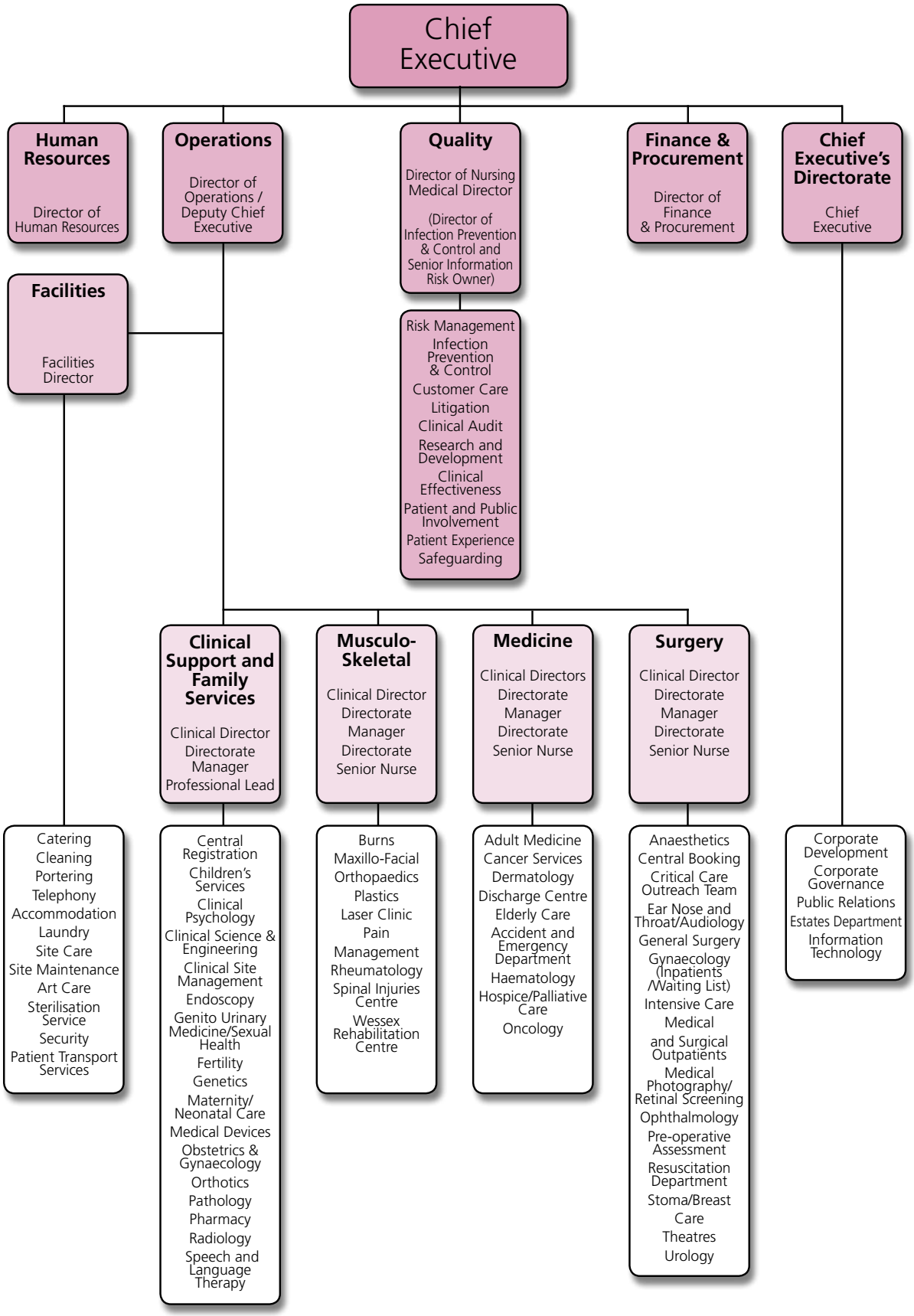
Integrity
We will be open and honest

Improvement
We will continually find better ways of delivering our services

Involvement
We will listen to colleagues and service users to shape our continuous improvement and development

Stewardship
We will respect our environment and use resources wisely

Organisational Structure



Directors of Salisbury NHS Foundation Trust During 2011/2012

Luke March DL	Chairman
Caspar Ridley	Chief Executive (From 1 March 2012)
Nigel Atkinson	Non Executive Director. (Vice Chairman and Senior Independent Director) until 30 Nov 2011
Christine Blanshard	Medical Director (From 5 September 2011)
Lydia Brown MBE	Non Executive Director. (Vice Chairman and Senior Independent Director) from 1st Dec 2011
Barry Bull	Non Executive Director
Malcolm Cassells	Director of Finance and Procurement
Alan Denton	Director of Human Resources
Ian Downie	Non Executive Director
Clare Fuller	Acting Medical Director (From 4 April 2011 to 4 September 2011)
Peter Hill	Chief Operating Officer (Interim Chief Executive until 29 February 2012)
Stephen Long	Non Executive Director
Tracey Nutter	Director of Nursing (Director of Nursing & Operations until 24 July 2011)
Jim O'Connell	Interim Chief Operating Officer (25 July 2011 to 29 February 2012)
Sean O'Kelly	Medical Director (until 18 April 2011)
Michele Romaine	Non Executive Director (until 31 January 2012)
John Stokoe CB, CBE	Non Executive Director

Companies Act Disclosures

Principal Activities of the Trust

At Salisbury District Hospital, Salisbury NHS Foundation Trust provides a range of clinical care, which includes general acute and emergency services, to approximately 225,000 people in Wiltshire, Dorset and Hampshire. Specialist services, such as burns, plastic surgery, cleft lip and palate, genetics and rehabilitation, extend to a much wider population of more than three million people. The Duke of Cornwall Spinal Treatment Centre at Salisbury District Hospital covers most of southern England with a population of approximately 11 million people. Trust staff provide outpatient clinics in other locations in Dorset and Hampshire. Specialist staff hold outreach clinics in hospitals within the Wessex area and, in total; the Trust employed 3,860 staff at 31 March 2012. This includes full and part-time staff.

The Trust also has a subsidiary company called Odstock Medical Limited. This was set up in 2006 to market worldwide its experience and knowledge of functional electrical stimulation and its own pioneering electrical devices. This is so that income generated could be used to further research and create new developments that help NHS patients in this country.

Research and Development

The Trust hosts the Research Design Service (SW) Salisbury Office, which advises researchers who are preparing a grant application. The South West RDS is part of the National Institute of Health Research (NIHR) and, as part of the regional structure; the Trust meets the research governance objectives set by the NIHR. The number of NHS patients taking part in clinical research in the Trust significantly increased in the 2011/2012 financial year with 614 people taking part in 48 National Institute of Health Research and Clinical Research Network studies hosted by the Trust, an increase of 68% of people taking part over the previous year. Participation in clinical research forms part of the NHS constitution and the NHS operating framework, and enables the NHS to develop new treatments and shape services in the future.

Provision of Information and Involvement of Employees

The Trust built on its existing processes for staff communications and consultation, and has good working relationships with Trade Unions and staff. Regular communication through face to face briefings, the Intranet, a Chief Executive's message and publications are enhanced by topic based communications where and when appropriate. This includes sessions on the NHS reforms. The Trust has continued to create awareness of the financial and economic factors that affect the performance of the Trust as well as information that relate to the development of the Trust, and the quality of its services. This is supported by executive led safety and quality walkrounds that not only enable staff to share any concerns, but also give the Executive team the opportunity to feedback their views on these key areas to ward staff. Financial information and the Trust's position is also shared regularly with the Trust's Trade Union representatives.

Please note that the Trust has disclosed information on the above as required under the Companies Act that is relevant to its operations

Operational Review

The Trust has continued to provide patients with fast access to good quality, safe care and meet its operational demands during 2011/2012, despite the continuing financial challenges faced by all NHS organisations. It has also continued to make real progress in many areas of patient care, with a particular focus on safety, quality and patient's experiences.

HIGHLIGHT OF THE YEAR
EXCELLENT REPORT BY CARE QUALITY COMMISSION
The Trust meets all essential quality and safety standards following a routine unannounced inspection of Salisbury District Hospital.

Attention to these important aspects of patient care were highlighted by the Care Quality Commission (CQC). Following a routine unannounced inspection at Salisbury District Hospital the CQC found that the Trust met all essential quality and safety standards. As part of the inspection the CQC talked to patients, staff and visitors, and observed the care people received in hospital. They also looked at care and treatment records, standards of cleanliness and the management of people's medicines.

In its report the CQC said that patients they spoke to were happy with their care and treatment and they felt involved in decisions made about them. The CQC also found that patient's rights to privacy, dignity and respect were fully promoted and that they received adequate nutrition and hydration. This was particularly important bearing in mind that care of the elderly has become a priority area within the NHS following reports of poor care in some NHS hospitals.

Another priority area for the NHS is the care of patients with dementia and, as part of a region-wide approach; all hospitals in the South West are implementing the eight South West Regional Standards for dementia care. These cover:

- Respect, dignity and appropriate care
- Agreed assessment, admission and transfer/ discharge processes
- Access to mental health liaison
- Dementia friendly environment and minimising ward moves
- Nutrition and hydration
- Contribution of volunteers
- Quality of End of Life Care
- Training and workforce development

Throughout the year the Trust made real progress against the regional objectives and introduced a number of service improvements which help ensure that dementia patients are treated with respect and dignity, and receive an appropriate level of care. Peer reviewers assessed the Trust against the eight standards and found a positive culture - with strong leadership and clear engagement on the issue of dementia care at all levels.

HIGHLIGHT OF THE YEAR
POSITIVE REPORT ON DEMENTIA CARE
Peer Reviewers find a positive culture and clear leadership and engagement across all areas and levels within the hospital

This was highlighted by a good spread of dementia champions across clinical and non clinical areas. They were also impressed with the interaction between staff and patients at mealtimes, which is particularly important for this vulnerable group of patients. Care of the elderly and issues around end of life care will continue to be a focus for the Trust. In terms of end of life care the Trust is working jointly with other health and social care organisations to ensure that patients are able to die in the setting of their choice and ensure that all who are involved in their care are aware of the patient's wishes.

Another area where there has seen significant improvement is stroke care and this was highlighted by the Avon, Gloucestershire, Wiltshire and Somerset Stroke and Cardiac Network which awarded the team a service improvement award. The award follows an assessment against a number of national measures and indicators and includes access to diagnostic scans, assessments, medicines and therapy, as well as the amount of time spent on a specialist stroke unit. For instance, nearly all stroke patients are admitted directly to the specialist stroke unit now, with 94% spending at least 90% of their time on the Unit. Patients are known to do better when treated on a specialist unit. Of the stroke indicators that are used nationally to assess stroke care, the team achieved all nine for over 80% of patients, highlighting a very high rate compared with other hospitals both regionally and nationally. This is the second year running that the team has won this award.

Quality will continue to be a key focus and, while the Care Quality Commission assesses compliance with essential quality standards, the primary responsibility for maintaining and improving quality remains with the Trust Board.

In doing so, the Board has to have regard for Monitor's Quality Governance Framework. Monitor is the NHS Foundation Trust regulator. The Trust has a range of systems to ensure that quality governance is not only embedded firmly within the culture of the organisation, but that it also forms a key part in Trust strategy – with processes in place to monitor and measure capability and performance and review individual services. This is maintained through a quality framework. Information is gathered from patient feedback, reports, audits, external agency and peer reviews, and from Trust staff at ward and departmental level through Trust Board led quality walks. This is discussed at directorate quality meetings and presented to the Clinical Governance Committee as part of the assurance process. The Trust has clear reporting lines through individual directorates, the Clinical Management Board and the Trust Board itself, which reviews performance through a comprehensive series of quality indicators that are discussed in public at Trust board meetings. Full details of the work the Trust is carrying out in this area can be found in the Quality Report and the Annual Governance Statement later in this Annual Report. It is important to note that there are no material inconsistencies between the Trust's Annual Governance Statement, Board reports required by Monitor's Compliance Framework and any reports arising from Care Quality Commission reviews. The Trust Board will continue to monitor the governance of quality through its quality framework.

Waiting times and access to treatment continue to be important factors for patients and are part of a number of performance indicators and quality measures that are monitored monthly by the Trust Board. In line with the NHS Constitution, the Trust again met the national 18 week pathway.

HIGHLIGHT OF THE YEAR

AWARD FOR BEST PERFORMING STROKE UNIT IN REGION

Improvements in Salisbury stroke care has resulted in a regional award for service improvement and quality of care.

HIGHLIGHT OF THE YEAR

IMPROVING QUALITY THROUGH EFFECTIVE STRATEGY

Quality maintained as key priority for the Trust.

All Trusts have to ensure that 90% of admitted patients – those whose treatment takes place as an inpatient or day case – have their initial outpatient appointment, any diagnostic procedures and treatment within 18 weeks of a GP referring the patient to hospital. The same applies to 95% of patients who receive their treatment as an outpatient.

HIGHLIGHT OF THE YEAR
EXCELLENT WAITING TIMES

Over 90% of patients admitted to Salisbury District Hospital were treated within 18 weeks of being referred by their GP. Over 95% of patients who needed an outpatient procedure were treated within 18 weeks of referral.

Referral to treatment times are part of a number of national and local performance indicators and quality measures that are important to patients and currently underpin the development and business of the Trust. These are monitored monthly by the Trust Board and will be reviewed in order to reflect any changes that may be required due to the publication of a new NHS Outcomes Framework for the 2012/2013 year.

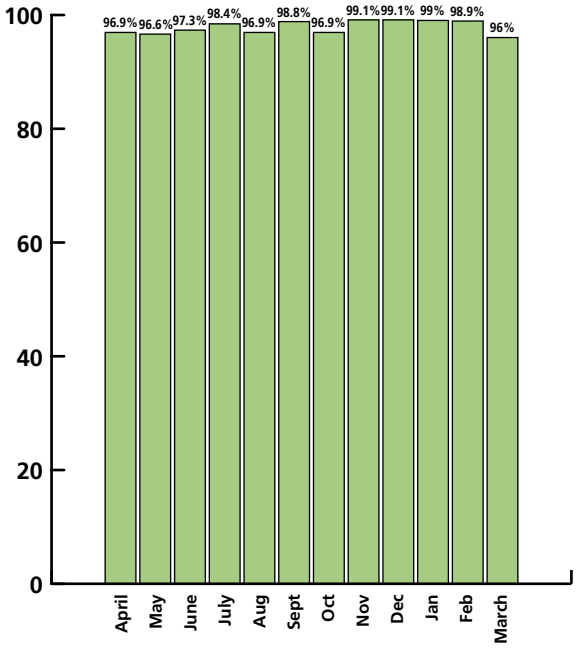
At the end of the 2011/2012 financial year the Trust met its cancer waiting time indicators. For instance, 94% (target 93%) of patients were seen within two weeks of referral from the GP and 93.3% (target 85%) treated within 62 days of GP referral. There was also good performance in diagnostic waiting times.

Salisbury District Hospital continues to have good mortality rates. The mortality rate is one of several indicators of healthcare quality, and measures whether a death rate in a hospital is higher or lower than expected based on national figures. The national average is calculated at 100 and the Trust's figure is in line with what would be expected for a hospital of its size, type and population it serves.

The Trust has continued with its work to streamline care for both planned and emergency patients and provide an efficient and effective service that improves patients' experiences of hospital care, reduces length of stay and, in some cases avoids unnecessary hospital admission.

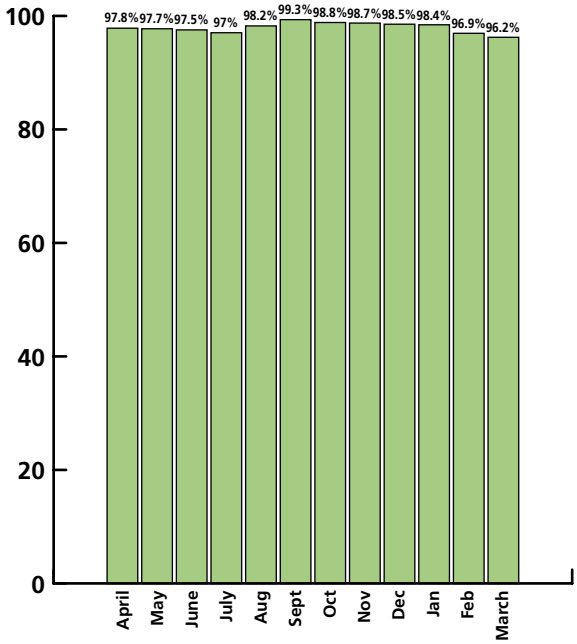
KEY PERFORMANCE INDICATOR
APRIL 2011 – MARCH 2012

Cancer Waiting Times – 31 days from decision to treat to treatment start.
Target: 96% for the year: Total 97.8%

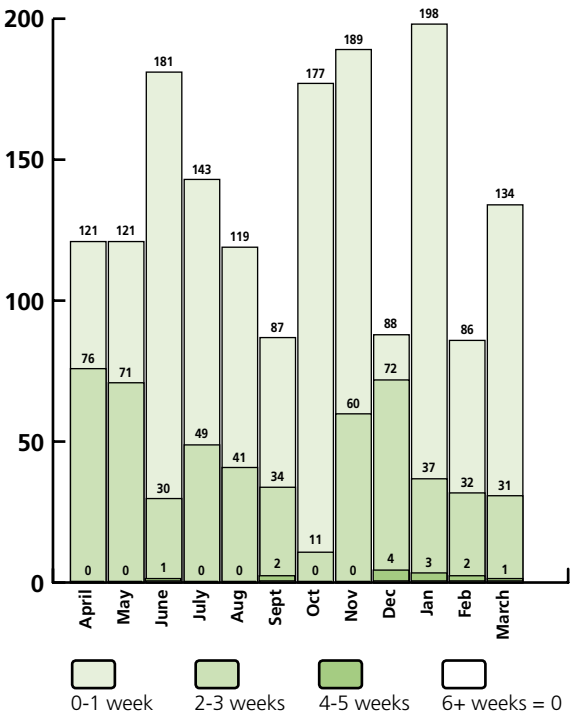


PERFORMANCE INDICATOR
APRIL 2011 – MARCH 2012

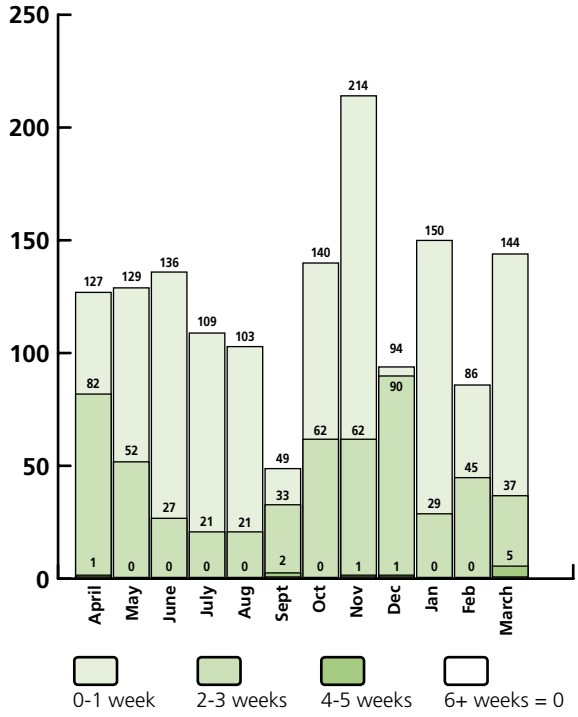
Proportion of A&E attendees who were admitted, treated or discharged within four hours.
Target: 95% for the year: Total 97.9%



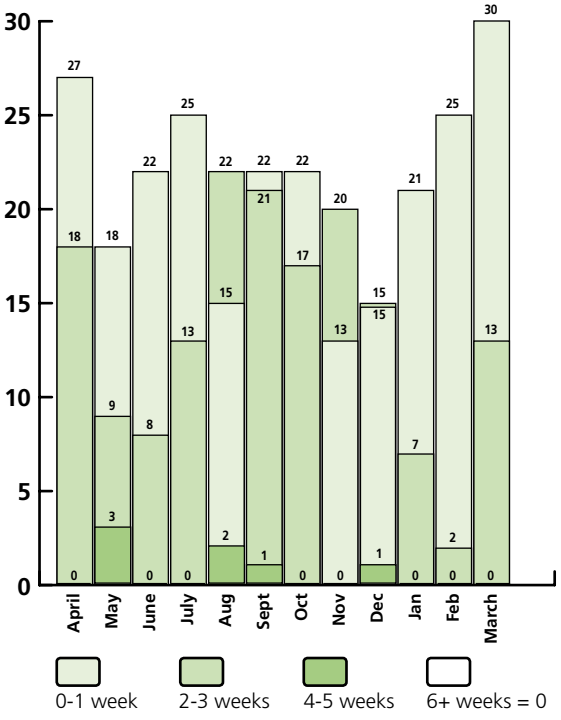
KEY PERFORMANCE INDICATOR
APRIL 2011 – MARCH 2012
Target: 6 weeks for a CT scan



KEY PERFORMANCE INDICATOR
APRIL 2011 – MARCH 2012
Target: 6 weeks for an MRI scan



KEY PERFORMANCE INDICATOR
APRIL 2011 – MARCH 2012
Target: 6 weeks for an angiography



In the previous year we reported on the Medical Assessment Unit (MAU) which is now able to send home patients without admitting them overnight, having had an assessment, tests and diagnosis within the day. On average 31% of patients are now discharged within 12 hours, with no increase in readmissions. However, in many cases GP access to specialist advice from a consultant meant that the GP did not feel the need to refer patients into hospital for assessment in the first place.

Reducing the length of time people need to stay in hospital is now recognised as a key measure in the overall quality of care provided and this year the Trust has made good progress in this area. This has been achieved through better access to fast, responsive assessment, more coordinated and integrated discharge planning and an expansion in the use of enhanced recovery programmes.

These programmes involve small changes to all aspects of care from the initial assessment through to post-operative care. Early mobilisation is key and together this ensures that patients keep well and return to their full normal fitness as quickly as possible after surgery. Enhanced recovery programmes are now used in colorectal, othopeadic, urology, and gynaecology and plastic surgery services.

HIGHLIGHT OF THE YEAR

MORE PATIENTS ABLE TO RETURN HOME EARLIER TO FAMILY AND FRIENDS

Increased use of enhanced recovery programmes have enabled the Trust to reduce the length of hospital stay for many patients.

Safety continues to remain a high priority and is monitored regularly through the Safety Steering Group and the Clinical Governance Committee, with safety performance reported at the Trust Board. As part of its commitment in this area, the Trust is involved in the regional safety programme led by the Strategic Health Authority. The Trust continued to improve in this area through increased staff involvement and engagement and this will carry on into the 2012/2013 year.

Cleanliness and good infection, prevention and control policies and procedures are essential to the safety of patients and the Trust again received an excellent rating for cleanliness, as part of the Hospital Environment category of the Patient Environment Action Team (PEAT) Inspection. The PEAT assessment includes patient and public representatives and modern matrons who have a central role in maintaining and improving standards at ward level, and hospitals are rated using a grading system of excellent, good, acceptable, poor or unacceptable.

Regular hand washing initiatives, cleanliness audits and the 'Tidy Tuesday' campaign, where staff put out unwanted items for removal are just some of the initiatives the Trust continues to use to limit the risk to patients and improve safety while in hospital. This continued as part of its ongoing infection prevention and control campaign, as did regular audits on antibiotic prescribing. Staff also used European Antibiotic Awareness Day to highlight the importance of prescribing antibiotics in appropriate situations. Antibiotics are an important treatment for patients, yet the increased use of antibiotics across the world is leading to an increase in antibiotic resistant bacteria, making it more difficult to treat patients with infections.

HIGHLIGHT OF THE YEAR

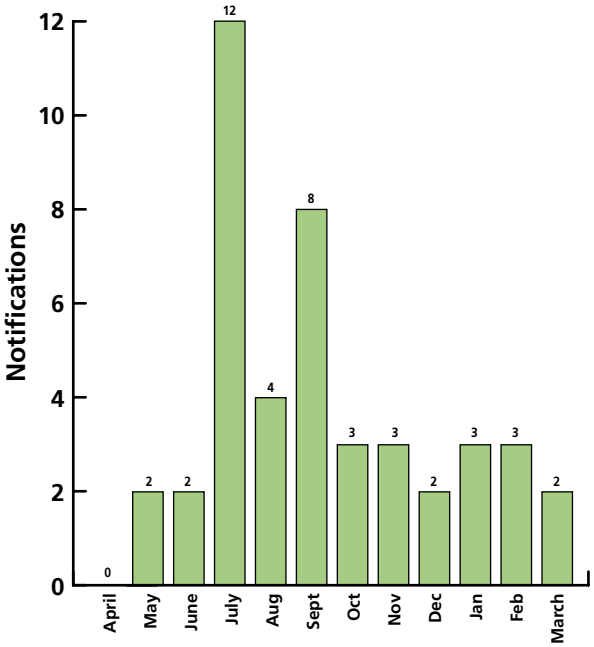
EXCELLENT CLEANLINESS

The Trust received an Excellent rating for Hospital Environment, Food Quality and Privacy & Dignity.

The Trust continues to strive towards maintaining low MRSA (Methicillin Resistant Staphylococcus Aureus) bacteraemia and Clostridium Difficile infection rates. The Trust did see a period of increased incidence in the number of individual Clostridium Difficile cases reported in July. While these were unrelated, as a precautionary measure the Trust implemented a deep clean programme and put in place additional cleaning to ensure that its high standards are maintained. When compared with other hospitals across the country, the Trust still continued to have low infection rates.

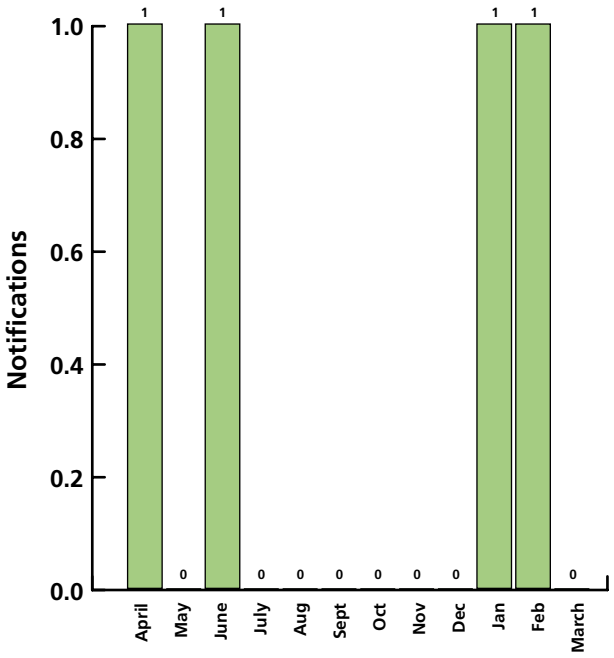
KEY PERFORMANCE INDICATOR APRIL 2011 – MARCH 2012

Clostridium Difficile. Target for Trust apportioned cases is 25. Total: 44



KEY PERFORMANCE INDICATOR
APRIL 2011 – MARCH 2012

Number of notifications of MRSA Bacteraemia made to the Health Protection Agency.
Target: 0 for year: Total 4



The NHS as a whole continues to face a number of other challenges and the NHS Reforms continued to move forward following a natural break in the legislative process and a re-assessment of the proposals by heath professionals, patient representatives, voluntary organisations and local Government, as part of the NHS Future Forum. While the key changes relating to national and local commissioning remained, there were changes and clarifications. These included the inclusion of hospital based health professionals from outside the area in local Clinical Commissioning Groups (previously GP 'only' consortia), greater quality controls through the move from any Willing Provider to Any Qualified Provider, and a clearer role for the independent regulator in promoting collaboration and integration rather than competition. Timescales were also extended for the abolition of Primary Care Trusts and Strategic Health Authorities. The reforms became law at the start of April 2012 to become the Health and Social Care Act 2012.

NHS reform aims to help drive quality and productivity improvements through a system of quality standards and ensure that clinical and financial priorities are matched. While the proposed changes are too wide-ranging and complex to cover in detail here, they will have an impact on the hospital, and its strategic objectives. In order to meet the challenge and the impact of proposed changes, the Trust Board identified six key work streams in the previous financial year led by an Executive and Non Executive member of the Board to review its current provision of clinical and non clinical services, its workforce needs and how to make best use of information technology and the hospital site. At the time of writing the Trust had started a review of its strategy under the direction of the new Chief Executive.

It is essential that the Trust continues to provide core district hospital services to a high standard. It is also important to develop its regional specialties, make better use of clinical networks where they exist, work in conjunction with other organisations to provide services outside the hospital and extend the range of its non-core commercial activities. Staff will continue to play a major part in the development of strategy, together with input from stakeholders, as we enter the new financial year.

New ways of working, staff innovation, investment in new technology and the modernisation of facilities have always played a key role in the Trust's ongoing development and play an essential part in the overall care provided to patents. For instance, during the year children's services moved away from wartime buildings into first class modern facilities based on level 3 and 4 of the existing hospital. The new unit includes parents' accommodation, home from home rooms, therapy facilities for children with disabilities, a multi-sensory room as well as indoor and outdoor play areas. Local children, schools and community groups had a key role to play in its development and the Unit won a Building Better Health Care Award in recognition of its unique child-friendly design and bright and sensitive internal decoration. The new bright and spacious wards now provide greater comfort and privacy for children and their families and themed areas and colourful surroundings engage children and distract them from clinical procedures.

HIGHLIGHT OF THE YEAR
CHILDREN'S UNIT WINS NATIONAL DESIGN AWARD

Children's Unit wins national award for its unique child friendly design and bright and sensitive internal decoration.

This year work also started on a new Neonatal Intensive Care Unit (NICU). This £800,000 redevelopment will see an older ward transformed into a new NICU and will be over three times the size of the current NICU, with modern first-class facilities. When completed the new NICU will be joined to the former NICU building, which will become the parent's accommodation, so that they can stay close to their babies. Currently parents have to make daily trips to visit their newborn babies in hospital. The Stars Appeal is raising over £350,000 towards the family accommodation aspect of the project with the remainder coming from the Trust's capital funds.

HIGHLIGHT OF THE YEAR
WORK STARTS ON NEW NEONATAL INTENSIVE CARE UNIT
New expanded NICU with accommodation for parents so that they can stay close to their baby.

Examples of innovation can be seen in the in-house development of a new electronic application that gives clinical staff access to patient information in one single, easy-to-use format to help in the care and treatment of their patients. The IT team has a history of developing IT systems that provide additional support and had previously developed a new electronic system that ensures that there is a more comprehensive handover of patients at night between clinical teams. This system attracted interest from other hospitals across the country.

HIGHLIGHT OF THE YEAR
INNOVATIVE NEW IT SYSTEM TO SUPPORT PATIENT CARE
Salisbury IT specialists develop innovative new electronic system that gives clinical staff improved access to patient information to help in the care and treatment of their patients.

Good patient care not only centres on treatment but also the prevention of accidents and illness. It also centres on ongoing support. This year staff worked hard on providing additional support or advice through health promotion campaigns in a number of areas such as breast care, oral cancer, arthritis and speech and language therapy.

HIGHLIGHT OF THE YEAR
VTE ASSESSMENTS FOR HOSPITAL PATIENTS
Over 90% of patients now receive a VTE assessment when admitted to hospital.

The venous thrombo-embolism (VTE) team also continued to build on the excellent work they have been doing on blood clots. All hospitals should have systems in place to see whether patients are at risk of developing VTEs while in hospital and over 90% of patients are now assessed in Salisbury. The Trust is an 'Exemplar' site for VTE and is in the forefront nationally on VTE prevention.

The Trust has a strong tradition of creativity, high quality research and innovation and this continues to be reflected in the work carried out by clinical scientists at Odstock Medical Ltd - the company set up by the Trust to market worldwide its revolutionary Odstock Dropped Foot Stimulator. The Trust generates new ideas through the Staff Governors Good Ideas Competition where there is a real emphasis on initiatives that could make a real improvement on patient care, the working lives of staff or save the Trust money. The Trust also implements ideas through Innovations South West and Trust staff have regularly received awards in this area.

This innovation, coupled with the organisational commitment to create greater access, convenience and choice is a fundamental strength of the Trust. This strength can also be seen in the way the Trust uses views and comments from patients, public and staff to improve services. Patients were involved in over 40 projects this year, using many different methods including patient stories, focus groups and questionnaires. It is important that patients have the opportunity to tell us about the care and treatment they receive in hospital, whether this is through patient and public Involvement projects, national patient surveys or our frequent feedback initiative where volunteers and Governors regularly tour the wards gathering patient's views. Feedback enables the Trust to use the individual experiences of patients to highlight emerging themes and issues so that we can focus attention on these and improve our services. For instance, in the latest national inpatient survey, noise at night, prompt answering of call bells and waiting times for people to take home medication are some of the themes which will provide a focus for improvements in the 2012/2013 financial year. Good performance around respect and dignity and the percentage of patients who rate their overall care were also features with 93% of patients rating their overall care at Salisbury District Hospital as excellent; very good or good. In the outpatient survey the Trust was in the top 20% of best performing Trusts in most questions covered.

HIGHLIGHT OF THE YEAR

PATIENTS RATE OUTPATIENT SERVICES HIGHLY

Privacy and dignity, cleanliness and satisfaction with outpatient services key positive findings in national patient survey.

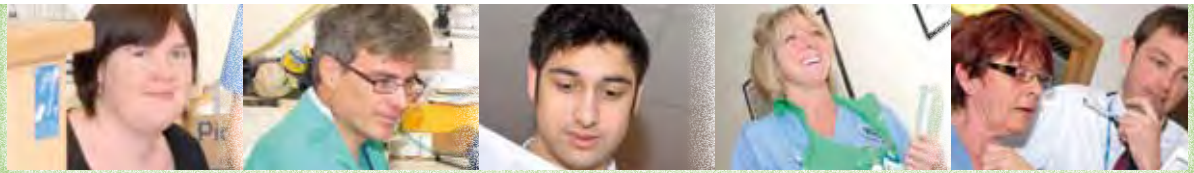
Patients' views are invaluable and the Trust has a frequent feedback initiative which gathers regular feedback from wards and clinical areas. Staff views are equally important to the development of services and the Trust continued to use their knowledge and expertise to improve services for patients through focus groups.

The Trust continues to work closely with organisations that commission services from the Trust to ensure that contractual arrangements are adhered to and that patients are treated in an appropriate and timely manner. While this currently involves Primary Care Trusts, during the year the Trust strengthened its links with evolving Clinical Commissioning Groups and met regularly with local GPs to discuss their ongoing and future needs. The Trust also works with other agencies, voluntary organisations and its key partners in health and social care. Major stakeholders - including Wessex Community Action - have a seat on the Council of Governors and the Trust also engages with the Overview and Scrutiny Committees.

As part of the Trust's commitment to the environment the Trust has its own Sustainability and Carbon Reduction Strategy and, as part of this, it continues to work with stakeholders to ensure that, where possible, the Trust uses renewable sources of energy. It also encourages alternative forms of travel through the Trust's Travel Plan and volunteers have carried out a major recycling drive – which has resulted in over 1,000 items of broken and damaged furniture bound for the skip to be re-used across the hospital. More information on the Trust's achievements in this area can be found in the Sustainability Report later on this Annual Report.

Continued high performance is important, as is good planning and a thorough assessment of risk. The Trust has a Risk Management Strategy which ensures that robust risk management processes are in place to assure the Trust Board that it is discharging its responsibilities effectively. The strategy ensures that key control processes are in place which informs the Trust Board of potential risks to the organisation and the actions being taken to resolve these risks. The Risk Register and Assurance Framework is the vehicle used to provide this information to the Board and this covers all departments. The Trust strongly encourages an open and honest culture in the reporting of any clinical and non-clinical incidents. In general, high reporting rates indicate a positive reporting culture and leads to a significant increase in the level of 'no harm' incidents. In reports compiled by the National Patient Safety Agency, the Trust has a high rate of reporting and no harm incidents that reflect the value in its approach to this issue.

Education, training, rewards, recognition and support are key principles that the Trust believes are important to ensure that Salisbury District Hospital recruits and retains the best staff. Good quality staff enable the Trust to provide high standards of patient care and this was clear in the quality and number of nominations for the Trust's Striving for Excellence Awards. These awards give staff recognition for their work and emphasises their importance to the continued development of the Trust and the strategic direction it takes in the future.



Financial Review

Once again this has been a challenging year. However the Trust has achieved its financial targets finishing the year with a £1.1m surplus and an overall financial risk rating of 3.

This was set against the background of the NHS reforms which saw the start of the transition to the new commissioning and management arrangements for the NHS and the continuing need to provide services more efficiently in both primary and secondary care. Nationally the NHS needs to make £20 billion savings by 2014/2015 and Primary Care Trusts are now working in clusters with shadow Clinical Commissioning Groups (CCGs) to provide more services in the community. This will impact on the Trust's own financial planning over the coming years.

Due to the overall financial position the Trust has an ongoing programme to make substantial efficiency savings. This means that we have to be more efficient and flexible in how and where we provide our services in the future, while maintaining high standards of care. For instance, we have continued to work with GPs and community services to reduce length of stay, avoid unnecessary admission to hospital and where possible provide more care and treatment in the community. This year the Trust has also been working closely with its local GPs to manage referrals more efficiently.

While patients will benefit from any changes that enable them to receive more care at home this will affect the hospital, and the Trust has continued to reduce bed numbers and staff posts. However, where we can generate additional money by offering services to other organisations we will look to do so. For instance the Trust successfully bid to provide payroll services to other Trusts. This brought in more money and additional payroll staff were employed to cover the extra work. This also took place in the Trust's laundry service which won further contracts.

Key Financial Targets Met

- Planned surplus exceeded
- Achievement of Level 3 Financial Risk rating as planned
- £9.6m savings achieved

As a result of the work carried out to improve efficiency the Trust had a savings target of £9.6m in 2011/2012 and finished the year with a surplus of £1.1m. This will help the Trust continue to develop services according to the needs of both the local and wider health communities. While the number of patients seen was broadly in line with the previous year, the demand management needed for a planned reduction in patients did not take place and the Trust did see more patients than was planned by our commissioners. The Trust has successfully bid for money that had been made available to Strategic Health Authorities to reduce waiting lists. This amount was £765,000.

Efficiency and Use of Resources

- High levels of efficiency maintained with overall costs 7% less than the national average
- Management and administrative costs contained within 3.6% of turnover

Patients Treated			
	2011/2012	**2010/2011**	**2009/2010**
Elective inpatient (spells)	**7,353**	**7,282**	**7,600**
Day cases	**19,559**	**20,082**	**22,217**
Non elective (spells)	**28,457**	**28,837**	**26,133**
Regular day attendees	**5,703**	**5,320**	**5,271**
Outpatients (consultant led)	**180,394**	**178,514**	**176,581**
New attends	(63,501)	(66,480)	(67,094)
Follow up	(116,893)	(112,034)	(109,487)
Accident and Emergency	**42,453**	**40,749**	**40,656**
New attends	(41,453)	(39,827)	(39,587)
Follow up	1,000	(922)	(1,069)
Spells are the main way in which hospital activity is recorded. A spell is the period of time from Admission to Discharge.			

In this challenging climate, the Trust needs to have an effective Assurance Framework – a set of risks that it acknowledges and monitors in order to ensure the viability of the organisation. These are linked closely to the Trust's financial and operational objectives and include: an assessment of income levels; provision of services and treatment; the achievement of budgetary targets and cost savings; general and financial targets. It also has a risk rating from the regulator for the achievement of plan, underlying performance, financial efficiency and liquidity and at the end of the financial year the Trust had an overall financial risk rating of 3. Cash flow remained reasonable and enabled the Trust to pay its staff and its bills promptly. This is reflected in the Trust's performance against the Better Payments Practice Code, with 72.2% of non NHS bills and 84% of NHS bills paid within the 30 day target. The Trust has made no political or charitable donations of its own.

Key financial indicators centre on a surplus financial position, net operating income, capital and assets, savings programmes and the Trust's cash position, as well as its Financial Risk Rating. Key financial indicators are monitored monthly by the Trust Board.

The Trust recognises that it has a challenging year ahead with a similar savings target as last year of around £9.6 million savings. This is because there is a need for the Trust to continue to make further savings due to reduced income from commissioners, changes in the national tariff and internal cost pressures.

Staff receive regular monthly updates, with key operational and financial information cascaded throughout the organisation, as well as the day to day communications that take place at different levels of the Trust. Open sessions for all staff continued on the Trust's financial position and the NHS Reforms, so that staff are able to put the Trust's position in context with the national perspective and proposed changes. The Chief Executive regularly sends out a personal message to all staff as part of the wider communication process.

Capital Expenditure

Capital Expenditure of £6 million was incurred in 2010/2012 and spent on a range of service developments. Capital projects included:

	£'000
Combined Heat and Power Unit	£558
New Neonatal Intensive Care Unit Facilities	£275
Patient Monitoring Equipment	£250
Specialist Equipment for Main Operating Theatres	£174

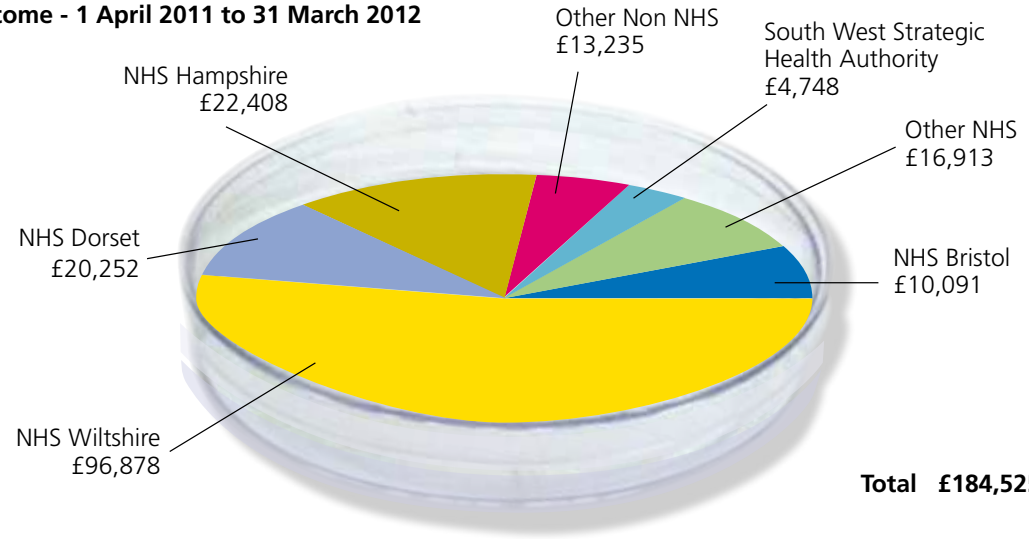
Investment in facilities and equipment has benefited patients in a number of ways and these can be viewed throughout this report.

Staff are also able to raise any issues during the Trust Board led safety walk rounds. Operational and financial information is presented in Public Board Meetings and placed in the public domain. The Trust's financial position is also assessed quarterly by the Regulator.

Income generated by Odstock Medical Ltd (OML), is being used to further research and create new developments that help patients. The Trust owns 68% of OML. The Trust can report that OML made a profit and this is reflected in the consolidated accounts. The Trust treats private patients through a partnership with Odstock Private Care Limited (OPCL). To support this, the Trust has a designated unit called the Clarendon Suite, where private patients can be treated on the Salisbury District Hospital site. While (OPCL) is contracted to provide private care on site, income generated is used to benefit NHS patients by supporting our services. There are also a number of treatments offered that are not available on the NHS. These are provided privately within departments without compromising our own NHS service. A good example of this is the Laser Centre.

Good relationships and the flexibility to explore new business and commercial opportunities will again be key to the Trust in the coming year, as will its performance around existing targets and the new NHS Outcomes Framework.

Sources of Income - 1 April 2011 to 31 March 2012



Total £184,525 million

Patient Care and Stakeholder Relations

During the year the Trust introduced a number of developments and initiatives that have directly or indirectly improved patient's experiences and the quality patient care at Salisbury District Hospital. The Trust has also worked in conjunction with a number of other organisations on projects that reinforce partnership working, stakeholder relations and staff involvement. These are summarised within the following themes:

TAKING CARE OF OUR PATIENTS

Introduction of Dementia Champions

As part of its dementia strategy the Trust introduced a number of service improvements which help ensure that dementia patients are treated with respect and dignity, and receive an appropriate level of care. This includes the launch of our dementia champions who are in place across the hospital and monitor standards of care, promote dementia training and ensure that staff have the skills they need to best manage the care of people with dementia and their carers.

Young at Heart Project Helps Elderly People

As part of the Trust's approach to provide additional support and help for older patients in hospital, the ArtCare Team developed a regular programme of creative activities. This has not only provided opportunities for physical and mental stimulation during patients' recovery, but potentially reduced length of stay and use of medication.

Campaign to Ensure Proper Drug Prescribing for Dementia Patients

Staff are working to the 'call to action' campaign run by the NHS Institute for Innovation and Improvement. This national campaign creates greater awareness of inappropriate prescribing of anti psychotic drugs to dementia patients. While the campaign acknowledges that there are clinical situations where a time limited prescription may be appropriate, evidence shows that these are often over prescribed. Staff have been working across the hospital to ensure that good practice is adhered to in this important area of patient care.

Supporting Adults with Learning Disabilities

The Trust has introduced a hospital passport for adults with learning disabilities that will help staff plan their care and make reasonable adjustments when they come into hospital. The passport is filled out by them, their family or carers and includes questions about personal needs, preferences and anything that could make them anxious or worried. The Trust has also developed an easy read feedback form in addition to the feedback card that has been available for some time on the wards.

Successful Staff Flu Vaccination Programme

Over 1,800 staff received flu vaccinations last winter as part of a successful campaign to protect patients and staff from the virus. Comprehensive staff vaccination helped reduce the risk of flu spreading across patient areas, affecting vulnerable patient groups. It also reduced the impact on staff sickness within the Trust.

Children Get Behind the Lens for Cleft Palate DVD

Children with cleft lip and palate enjoyed a unique opportunity to make their own information DVD and help other children who will need an alveolar bone graft operation to correct the cleft in the jaw bone. The DVD includes the experiences of children between 8 and 12 years of age which helps reduce the worry that some children and their families have before the operation.

Patient Information at Salisbury District Hospital

The Trust has continued to develop information for patients and their relatives. The Day Surgery Unit has updated all its information sheets and many other departments have written new ones. These can all be found on the Trust's website. A working group looks at different types and styles of patient information, and members of the public comment on patient information including leaflets, web pages and DVDs as part of the Readership Panel. A number of new Easy Read leaflets have been written by a group of adults with learning disabilities helped by a support worker and member of staff.

Trust Retains Patient Information Standard

The Trust has retained the Information Standard from its external assessors, the Royal Society for Public Health. This ensures that the Trust continues to provide high quality health and social care information. Salisbury is one of only 11 hospital Trusts across the country that has been accredited with the Information Standard. The aim of the scheme is to reduce the potential for sub standard health and social care information and ensure that patients, public and health professionals know that the information that they are using is reliable and can be trusted.

PROMOTING BETTER HEALTH AND SUPPORT FOR OUR PATIENTS

Antibiotic Prescribing Awareness

Staff used European Antibiotic Awareness Day to highlight the importance of prescribing antibiotics in appropriate situations. Increased use of antibiotics across the world is leading to an increase in antibiotic resistant bacteria, making it more difficult to treat patients with infections. Prudent use of antibiotics and good practice formed a key message of the campaign.

Events Raise Awareness of Speech and Communication Difficulties

Salisbury therapists gave people an opportunity find out more about speech and language difficulties and the value of communication at several events as part of the national Giving Voice campaign. Children were able to take part in a number of activities that support and develop children's communication skills in everyday play. The team also provided information about all forms of support available locally.

Medics 'Get on their Bike' for World Arthritis Day

The Rheumatology Team 'got on their bike' at Salisbury District Hospital on World Arthritis Day to highlight the benefits of movement. The team gave advice and information to patients, visitors and staff, while cycling through the day to raise awareness of exercise for people living with arthritis.

People Learn more about Skin in Specialist Talk

Foundation Trust members had an opportunity to find out how skin works and the wide range of skin conditions, in an enthralling talk given by Consultant Dermatologist, Dr. Richard Meyrick -Thomas. Dermatology in Salisbury – Skin Care was part of the popular Medicines for Members talks given by hospital specialists.

25th Anniversary of Special Lunch for Breast Cancer Patients

Eighty-two year old Enid Crook cut the Breast Care lunch anniversary cake, 25 years after she first came along to the lunch held annually by the Hospital's Specialist Breast Care Team. Twelve ladies first came along to this unique event, which has given past and present patients an opportunity to enjoy each other's company and support. This year 150 women shared their experiences and provided additional support to women newly diagnosed with breast cancer.

Oral Cancer Awareness

Staff highlighted the lifestyle factors associated with oral cancer with smoking and excessive alcohol consumption common causes. There has been a 46% rise in cases of mouth cancer over the last 10 years, making it one of the fastest growing cancers in the UK. There has been a sharp rise in the number of young people being diagnosed. The first sign of mouth cancer is often a non healing ulcer or red patch in the mouth and people are encouraged to check their mouth regularly and visit their dentist if they are worried. A diet rich in fruit and vegetables can also help prevent cancers.

Local Stop Smoking Campaign

Salisbury District Hospital is one of a number of locations that is displaying Smokefree South West banners as part of a commitment to raise the profile of Stop Smoking initiatives and point people in the direction for support in kicking the habit. Fourteen giant banners are situated in locations across the site. Some of the banners also offer help to people who want to stop smoking by giving them contact details of the NHS stop smoking service.

New Drive to Increase Organ Donations

Staff urged people to sign up to the organ donor register and share their wishes with family and friends as part of a drive to increase the number of organ donations. Although 60% of people say they would support organ donation many have still not signed up. The campaign gave staff the opportunity to highlight the key message and outline the advice and support that can be given in cases where organ or tissue donation may be possible.

MAINTAINING PERFORMANCE FOR OUR PATIENTS

Excellent Dementia Peer Review

The Trust has had a positive independent peer review which covered the care given to people with dementia. Reviewers observed care on wards and outpatient areas and talked to staff. The assessment team were impressed with the motivation and professionalism of staff, leadership at operational and Board level, and the positive culture within the Trust. They also highlighted the enthusiasm of clinical and non clinical dementia champions the way in which staff at all levels and areas are involved.

Good National Stroke Audit

The Salisbury District Hospital Stroke Service has performed well in the national audit carried out by the Royal College of Physicians. The audit covers 26 key standards covering three stages of assessment, planning of care, communication with patients and carers and the overall care patients receive while in hospital. The Trust was in the upper quartile for its total score and also its overall position within the country.

Excellent Rating for Food, Environment and Privacy & Dignity

Salisbury District Hospital has again been given top marks for the hospital environment, food quality and privacy and dignity in a national report by the National Patient Safety Agency. The report follows an assessment made earlier in the year by the Patient Environment Action Team (PEAT). The PEAT team include patient and public representatives, governors and modern matrons who have a central role in maintaining and improving standards at ward level.

Inpatient Survey

In the latest inpatient survey respect and dignity and whether patients felt they were sharing accommodation with a person of the opposite sex when first admitted were two examples of the positive findings from patient's comments. However, there were areas where the Trust does need to make improvements. These include noise at night and answering of call bells. A full action plan will be developed and monitored at Board level.

Patients Rate Outpatient Services Highly

Patients have rated the outpatient services highly as part of a national survey carried out in all general and specialist hospitals by the independent Care Quality Commission. Patients were asked questions relating to their appointment, care and treatment, the hospital environment and their overall impression of the service. The Trust was amongst the top 20% of best performing hospitals in most of the questions covered, with privacy and dignity, cleanliness, confidence in staff and satisfaction with outpatient services key findings in the survey.

Parents Rate Neonatal Intensive Care Unit

The Trust has received excellent feedback from families who have had babies on our Neonatal Intensive Care Unit. This covers all aspects of care - from the way in which families felt they were treated by staff, to the standard of treatment they received. Confidence in staff, involvement in decisions and the way in which our staff were sensitive to the emotions and feelings of parents were just some of the strong points in the feedback.

Good Parliamentary and Health Service Ombudsman's Report

The Ombudsman published its review of complaint handling by the NHS in England for 2010/2011 which identified complaints where the Ombudsman had intervened, where Trusts had received the highest amount of complaints, those where the Ombudsman accepted them for formal complaints. The Ombudsman received only 17 complaints about the Trust (one of the best in England), and felt that none of these required any further formal investigation.

Comments, Concerns, Complaints and Compliments

Last year the Trust treated 61,068 people as inpatients, day cases and regular day attendees. Another 42,453 were seen in A&E and 180,380 as outpatients. The Chairman, Chief Executive and Customer Care Department received 1,876 thank you letters/cards, with many more sent directly to staff on wards and units. There were 685 general enquiries, 203 comments, 689 concerns and 320 complaints. The overall number of comments, concerns and complaints responded to in 0-10 working days was 685 (56%), in 10-25 working days 386 (32%) and above 25 working days 141 (12%). All comments, concerns and complaints were acknowledged either verbally or in writing within three working days. Nine complaints were referred to the Parliamentary and Health Service Ombudsman for independent review and, to date seven have not been upheld. The Trust is awaiting a decision on two cases.

The Trust welcomes feedback as this is used to improve the quality of its services. Areas where improvements were made following complaints include:

- The early recovery programme in orthopaedics has seen a reduction in the average length of stay for patients following total hip and total knee replacement surgery.
- Changes were implemented to the pre-natal reporting protocol and all reports are now independently checked by three appropriately qualified staff.
- Education package for diabetic medication prescribing and administration.
- Clinical Lead for Cancer Services has been working with Southampton Hospital to review communication for shared care patients.

More detail about improvements can be found in the Trust Board quarterly reports.

IMPROVING SERVICES AND FACILITIES FOR OUR PATIENTS

Upgrade of Bedside Communication Systems

Hospedia, which provides the patient bedside communication system, has upgraded the current system with touch screen technology at no extra cost to the Trust. The new screens are now easier to use and have more functions that will benefit both patients and staff. There is s also a potential for clinical staff to access information at the bedside.

Burns Patients Benefit from Renovated Roof Garden

Burns patients who need a quiet area for relaxation and therapy now benefit from a £500 renovation of the roof garden. The renovation has been funded by the B.U.G.S. (Burns Unit Group Support) charity and includes a newly planted herb and vegetable garden, plants and shrubs, together with new garden furniture.

Patients Benefit from £5,500 Refurbishment of Ultrasound Waiting Area

Patients who need an ultrasound scan now have a more spacious and welcoming area to change and wait for their diagnostic test thanks to a £5,500 refurbishment of the waiting area. The refurbishment was funded by Salisbury Hospital League of Friends and includes new seating, sensitive lighting and decoration. Cubicles have also been rebuilt and doors added to replace curtains.

Retinal Screening Improvements

The Salisbury and North Hants Retinal Screening Service has put in place a new computer system and recruited additional screening staff to improve the service for people from South Wiltshire and Hampshire. The improvements enable staff to provide additional clinic locations and appointments for patients and a faster turnaround time for results following screening. It also gives staff better access to information needed in the diagnosis and treatment of their patients.

Trauma Unit Designation

The Trust was successful in its application to become a designated Trauma Unit. As part of the process the Trust had to meet a wide range of criteria relating to the level and quality of its emergency medicine and ensures that it can continue to provide accident and emergency services at Salisbury District Hospital in the future. The Trust is also planning to provide the plastic surgery and specialist rehabilitation elements to the University Hospital Southampton NHS Foundation Trust regional Major Trauma Centre.

Roktalk' on Trust Website

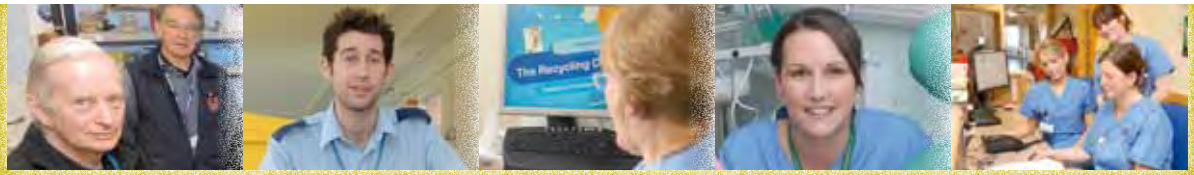
The Trust has put in place ROKTalk, which is a system that makes it easier for people with differing needs to access and use information on our website. With ROKTalk people can hear written text spoken aloud in a clear life-like voice in a number of different accents and languages, without the need for them to download any software.

Enhanced Recovery Programme for Hip Replacements

The Orthopaedic Multidisciplinary Team has introduced an Enhanced Recovery Programme (ERP) for hip replacement patients as length of stay (LOS) was above the national average. Changes to processes and clinical care and treatment resulted in a reduced LOS average from 8 to 5.5 days with no adverse effect on complication rates.

Improvements in Care of the Fracture Neck of Femur (NoF) Patients

The Trust wanted to improve its performance against key standards for fractured NOF patients. These relate mainly to timely access to specialist orthogeriatric care and treatment following injury. A greater orthogeriatric focus and continuous service improvement resulted in improvements and 16th ranking out of 160 hospitals.



Remaining Clothed for Radial Diagnostic Coronary Angiography

Patients having a diagnostic coronary angiogram can be worried, with the wearing of a 'gown' thought to contribute to this anxiety. Following an audit, the majority of patients felt more relaxed by wearing their own clothes, which improved their overall experience. This is now standard practice in this, and other, cardiac procedures.

Improvements in Cardiology and Orthopaedics Through Kings Fund Project

The hospital was chosen by the Kings Fund as a pilot site to improve patient pathways for two groups of patients – Ischemic Heart Disease and Orthopaedic Trauma. Service reviews and public engagement has led to improved processes, communication and information and more responsive care for patients and carers.

IMPROVING EFFICIENCY TO SUPPORT PATIENT CARE

Staff Governors' Good Ideas

Clinical Support Officer, Peter Goodyear, and Business Relations Manager, Alison Herod, jointly won the Staff Governors' Good Ideas initiative. Both Peter and Alison had similar ideas relating to the rail warrant process which is used by staff on Trust business. Both suggested a more co-ordinated approach which will save the Trust money. It could also be used to buy discounted packages for travel, hotel and parking where appropriate.

Trust Wins Contract to Provide Payroll Services to another NHS Organisation

The Payroll team have won the contract to provide payroll services to another NHS organisation, having provided an interim service to them over the past year. The team are also providing an interim service to another Trust pending a formal tendering process. This reflects the quality of the service and is a good example of the innovative way in which the Trust can generate additional income. The expanded service could be used elsewhere and the Trust is in negotiation with other Trusts.

New Delivery and Distribution Service

As part of the Trust's ongoing cost savings and efficiency review the procurement department awarded a contract to a new supplier to provide delivery and distribution services to the Trust. The change involves products that were primarily bought from the NHS Supply Chain. By switching, the Trust is expected to make significant savings against the current annual expenditure of the £3m.

Sunflower Cream

The hospital has re-launched its Sunflower Cream with new labels and a range of promotional materials designed by the ArtCare Team. The pharmacy has been making and supplying this moisturising cream for use in the hospital and for members of the public for over 25 years. The use of Sunflower Cream as a moisturiser is endorsed by Consultant Plastic Surgeons.

Recycling Volunteers

As part of a wider initiative to reduce overbuying, the recycling volunteers now refurbish and recycle old furniture that can be re-used within the hospital, bought or sent to Africa to prolong their use. In one year, they handled 1,000 items, diverting these from landfill sites and generating additional income for the Trust.

Staff Celebrate First Five Years of Pioneering Microbiology System

Staff in the microbiology department joined company representatives to celebrate the 5th anniversary of the introduction of the pioneering electronic Kiestra system that is used to process bacterial specimens. Salisbury District Hospital was the first hospital in the World to use the system which has revolutionised the way in which bacteriological specimens are grown, recorded and analysed, and helped provide a more efficient service for GPs and hospital teams.

RECOGNISING INNOVATION THAT IMPROVES PATIENT CARE

Local Burns Team Attract Top International Specialists to Salisbury

Pioneering work by the Salisbury Burns Team and a national reputation for burn care attracted around 300 health professionals from across the world to the British Burn Association's annual scientific conference at the Salisbury Playhouse. The conference, hosted by the Salisbury District Hospital Burns Team, gave fellow specialists the opportunity to hear about the latest techniques and revolutionary treatments being used in Salisbury and other units and centres and share best practice on burn prevention and support.

IT Specialists Develop Innovative New System to Support Patient Care

IT specialists at Salisbury District Hospital have developed an innovative new electronic application that gives clinical staff access to patient information in one single, easy-to-use format to help in the care and treatment of their patients. Clinician's View enables doctors and nurses to access all information sources electronically and create one single page of key information that they need during a patient consultation.

Expansion of Award Winning Psychology Project for Older People

The Salisbury District Hospital psychology team expanded its award winning programme of social and cognitive stimulation to cover all elderly care wards. This followed a pilot study run on Farley and Redlynch wards which found that an increase in the amount of cognitive and social stimulation for elderly patients in hospital can help decrease levels of anxiety and depression which is common in older people.

RECOGNISING AND REWARDING THE BEST

Salisbury Consultant Wins Military and Civilian Health Partnership Award

Consultant Plastic and Reconstructive Surgeon Roderick Dunn was named as the Healthcare Civilian of the Year. Mr Dunn won the award for the pioneering surgery he carries out with his consultant colleague Miss Alex Crick at Salisbury District Hospital on injured soldiers from Afghanistan and Iraq. The Health Care Civilian of the Year is one of nine categories in the Military and Civilian Health Partnership Awards, which is run by the UK health departments and the Ministry of Defence.

Best Young Volunteer for 2011

South Wilts Grammar School student Emma Preedy was rewarded for her dedication and commitment to patients when she received the Trust's Young Volunteer Award. Emma spent around two hours a week throughout the year helping patients and staff on Laverstock Ward where she provided additional support to ward staff, helping with tea rounds, serving meals and making beds.

Senior Sister Wins Leadership Award

Pitton Ward Senior Sister Angela Huxter won a leadership award level for the way in she encouraged staff to develop and achieve personal or organisational goals. Highly respected and admired by all who know her, visitors to the ward regularly comment on her welcoming style and leadership.

Surgeon's Outstanding Contribution Recognised

Colorectal Surgeon Helen Chave won a Striving for Excellence Outstanding Contribution Award. Helen is the driving force behind the introduction of Enhanced Recovery Programmes within her own area and she has contributed significantly to their use in other parts of the hospital. Her award recognised her innovation in supporting the expansion of ERPs, which improve patient care.

Bereavement Officer Chosen as Unsung Hero

Bereavement Officer Jackie Gaussen was named as the Trust's Unsung Hero in recognition of her consistent high standards of care. Jackie provided a highly sensitive and caring service, guiding grieving relatives through the bereavement formalities and going well beyond what is expected of her role.

Staff Win Awards for Customer Care

Outstanding customer care was recognised in two separate awards given to Salisbury District Hospital staff. Assistant practitioner Maria Bunn won an award for her caring and professional approach to patients and the dermatology team won an award for their clinical skills, friendliness and caring efficiency.

Nurse Wins Award for Staff Mentoring

Day Surgery Nurse Heather Durham won the Pinder Award for the way in which she supported students through their training. The award is supported by the Salisbury Rotary Club and candidates are nominated by students themselves.

Dedication of Volunteers Rewarded

Roger Green who Volunteers in the Hospice and Pembroke Unit was rewarded for his dedication, adaptability and reliability by picking up a Trust Striving for Excellence volunteers' award. As a bereavement support officer he works with the Family Support Unit where his empathy and understanding is a key asset to the areas where he works.

CELEBRATING ACHIEVEMENTS

Stroke Improvements

The stroke service has been rewarded for improvements that they have made in acute stroke care as part of a regional improvement programme. With Trusts awarded points based on their work, the Salisbury team was first and received funding to share their findings at the World Stroke conference in Brazil. These awards support improvements in performance, patient care and leadership and is the second year running the team has won this award.

Salisbury District Hospital Geneticist Wins International Honour

Patricia Jacobs, Professor of Human Genetics at Salisbury District Hospital, won a major international scientific prize from an American medical charity, The March of Dimes. The highly prestigious March of Dimes Prize in Developmental Biology is awarded to researchers whose work has contributed to our understanding of the science that underlies birth defects, and Professor Jacobs joins a number of eminent scientists and several Nobel Laureates who have previously won the award.

Children's Unit Wins National Design Award

The Children's Unit won a national Building Better Health Care Award in recognition of its unique child-friendly design and bright and sensitive internal decoration. Local children, schools and community groups had a key role to play in its unique design to ensure it was light and sensitive to the particular needs of children and families.

WORKING WITH OUR STAKEHOLDERS, PARTNERS AND LOCAL COMMUNITY

Equality is for Everyone Event

The Trust held a special event to highlight equality issues and ensure that it continues to meet its legal and moral responsibilities in this area. A number of external organisations including Age UK, the Wiltshire Blind Association and Salisbury Coalition Against Racism attended, and their views and comments are being used to influence Trust policies in this area.

Cultural Awareness

Hospital staff highlighted the cultural diversity that exists within the hospital and the positive benefits of working and living in a multi-cultural society at a special event organised by Salisbury Coalition Against Racism. Children from local schools were also invited and they enjoyed the cultural activities that reflect the diversity within south Wiltshire and took away positive messages about other customs and cultures.

Salisbury Awarded 'NHS Equality and Diversity Partner' Status

Following a rigorous application process the Trust was named as one 13 NHS organisations nationally that has been awarded 'NHS Equality and Diversity Partner' Status. The partnership enables the Trust to promote and champion equality and act as a resource to other NHS organisations. Work that takes place in Salisbury will also influence Department of Health and wider national policy.

SUPPORTING OUR STAFF TO PROVIDE BEST CARE

Get Fit - Health Manager

Staff are now able to use a new, free on-line personal health and wellbeing programme called Health Manager. The confidential programme enables staff to gather information about their health and lifestyle and produce a personalised wellbeing assessment report. It also provides suggestions for improvement and a wealth of information and services to help them.

Long Service Awards 2011

Thirty nine members of staff were rewarded for their loyalty and commitment to patients when they received long service awards for completing 25 years continuous service. The Trust held a special ceremony, and those who were able to attend were presented with their certificate, flowers and a gift from the Chairman and Chief Executive of the Trust.

NHS Retirement Fellowship

The Trust has been working with the NHS Retirement Fellowship (NHSRF) to help publicise their activities to hospital staff who are nearing retirement. Former NHS employees in Salisbury run the NHSRF, which provides an opportunity to meet with old colleagues and offer support to those who are unwell or who may be experiencing problems. The NHSRF also offers a busy programme of things to do such as social events, meetings with speakers and an opportunity to learn new skills.

Salary Sacrifice Car Scheme for Staff

The Trust has launched a new benefit called the salary sacrifice car scheme for staff which enables them to drive a brand new, environmentally friendly, fully maintained and insured car for up to three years. The scheme is through a salary sacrifice arrangement and staff can save both income tax and National Insurance each month, and benefit from 'corporate buying power' and NHS fleet discounts.

NUMBER OF EMPLOYEES IN POST AT 31 MARCH			
	2012	**2011**	**2010**
Medical and Dental	381	379	382
Administration and Estates	862	889	952
Other Support Staff	348	343	353
Nursing and Midwifery	1,562	1,609	1,719
Scientific, Therapeutic & Technical Staff	707	697	710
Total	3,860	3,917	4,116
At 31 March 2012 the Trust employed 3,860 full and part-time staff (Equivalent to 2,703.82 full-time posts)			

Background Information

History of the Trust

Consistently high standards and excellent financial management enabled Salisbury Health Care NHS Trust to start its application for NHS Foundation Trust status in the latter part of 2005. This led to authorisation under the Health and Social Care (Community) Act 2003 (now National Health Service Act 2006) on 1 June 2006, and a new name – Salisbury NHS Foundation Trust.

Statement on disclosure to the auditors.

As far as the Directors' are aware there is no relevant audit information of which the auditors are unaware. Each individual director that has approved this Annual Report has taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of the information.

Preparation of accounts.

The accounts have been prepared under a direction issued by Monitor.

Accounting Policies for Pensions and other Retirement Benefits

These are set out in note 10 to the accounts and details of senior employees' remuneration can be found in the Remuneration Report.

Going Concern

As part of the Trust's formal reporting requirements the Trust has to provide a statement on whether the accounts were prepared on a going concern basis. After making inquiries, the directors have a reasonable expectation that Salisbury NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Remuneration Report

Remuneration Committee

The Remuneration Committee reviews the salaries of the Executive Directors of the Trust and the individual reward packages of Executive Directors. These are fixed in comparison with packages given to holders of similar posts within the NHS. A salary range for each Director has been determined based on salaries paid across the NHS for similar posts. In setting, monitoring and reviewing salary ranges, the Committee uses survey material and receives independent advice and guidance as and when required from an organisation specialising in this work. During the year Interim Chief Executive Peter Hill and Director of Human Resources Alan Denton provided advice to the committee. The Head of Corporate Governance, John Williams, provided administrative support.

Name	Role	Attendance from four meetings
Luke March	Chairman	4
Nigel Atkinson	Member	4
Lydia Brown	Member	4
Barry Bull	Member	2
Ian Downie	Member	4
Stephen Long	Member	3
Michele Romaine	Member	3
John Stokoe	Member	4

The personal performance of the Executive Directors was assessed against their job description and their achievement of objectives, agreed by the Remuneration Committee in advance. An individual performance review (IPR) was held at the mid-year position and at the end of the year between each Executive Director and the Interim Chief Executive (or the Chairman in the case of the Interim Chief Executive's performance). The Remuneration Committee received reports in respect of the outcome of the IPRs.

Advancement within the individual salary scales of Executive Directors based on successful IPR outcomes is the only performance-related element of Executive Director's remuneration. An overall limit in the cost of movement is agreed by the Remuneration Committee prior to recommendations for advancement being made. In line with the two-year pay freeze for NHS staff earning more than £21,000 per year, no pay rise was awarded for the year starting 1 April 2011.

Responsibility for setting the terms and conditions of Non Executive Directors rests with the Council of Governors. In 2006, the Governors took independent advice when reviewing the existing terms and conditions and those agreed were based on the enhanced role for the Chairman and Non-Executive Directors of the Trust and levels of pay in NHS Foundation Trusts of a similar size and nature at the time. Subsequent independent reviews in 2008 and 2009 resulted in a modest uplift. In 2010 the Council of Governors decided not to award a pay increase to the Non Executive Directors following the example set by the Remuneration Committee on Executive Director's pay and this was repeated in 2011.

There is no bonus scheme for Executive Directors and any in-scale annual increment is based solely on individual performance. None of the current Executive Directors are subject to an employment contract that stipulates a length of appointment (see section on Trust Board Employment terms). In determining director's pay the Remuneration Committee for the executive directors and the governors in respect of the non executive directors sought to ensure pay awards reflected the current economic climate.

SALARY AND PENSION ENTITLEMENT

Remuneration						
	Salary (Bands of £5,000) £000		Other Remuneration Bands of (£5,000) £000		Benefits in Kind Rounded to the nearest £100	
	2010/2011	2011/2012	2010/2011	2011/2012	2010/2011	2011/2012
Luke March Chairman	40-45	40-45	0	0	0	0
Caspar Ridley Chief Executive	0	10-15	0	0	0	400
Nigel Atkinson Non Executive	15-20	10-15	0	0	0	0
Christine Blanshard Medical Director	0	90-95	0	0	0	0
Lydia Brown Non Executive	10-15	10-15	0	0	0	0
Barry Bull Non Executive	10-15	10-15	0	0	0	0
Malcolm Cassells Director of Finance	110-115	115-120	0	0	4,000	4,000
Alan Denton Director of Human Resources	90-95	95-100	0	0	4,000	4,000
Ian Downie Non Executive	10-15	10-15	0	0	0	0
Clare Fuller Acting Medical Director	0	70-75	0	0	0	0
Peter Hill Chief Operating Officer	120-125	140-145	0	0	4,100	4,300
Stephen Long Non Executive	10-15	10-15	0	0	0	0
Matthew Kershaw Chief Executive	85-90	0	0	0	4,200	0
Tracey Nutter Director of Nursing	105-110	100-105	0	0	0	0
Jim O'Connell Interim Chief Operating Officer	0	75-80	0	0	0	0
Sean O'Kelly Medical Director	165-170	0-5	0	0	0	0
Michele Romaine Non Executive	10-15	10-15	0	0	0	0
John Stokoe Non Executive	10-15	10-15	0	0	0	0

Benefits in kind relate to either the provision of a car or additional pension contributions

Matthew Kershaw was seconded to the Department of Health from 9 November 2010 until his resignation on 30 September 2011. Peter Hill was Interim Chief Executive from 9 November 201 0until 29 February2012. Caspar Ridley was appointed on 1 March 2012. Sean O'Kelly resigned on 18 April 2011. Clare Fuller was Acting Medical Director from 4 April 2011 to 4 September 2011. Christine Blanshard was appointed Medical Director on 5 September 2011. Jim O'Connell was Interim Chief Operating Officer from 25 July 2011 to 29 February 2012- he was on secondment and his salary was paid to South Central Strategic Health Authority. Michele Romaine resigned as a Non Executive Director on 31 January 2012.

Pension Benefits 1 April 2011 – 31 March 2012								
	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension and related lump sum at age 60 at 31 March 2012 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2012 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 1 April 2011 £000	Real increase in Cash equivalent Transfer Value £000	Employers contribution to Stakeholder pension To nearest £100
Caspar Ridley**	0-2.5	0-2.5	10-15	0	117	72	4	0
Christine Blanshard	5-7.5	15-17.5	200-205	150-155	907	652	134	0
Malcolm Cassells	0-2.5	2.5-5	205-210	150-155	1,127	1,028	67	0
Alan Denton	0-2.5	2.5-5	145-150	105-110	826	752	51	0
Clare Fuller	0-2.5	5-7.5	180-185	135-140	717	643	23	0
Peter Hill	5-7.5	20-22.5	210-215	155-160	981	751	207	0
Jim O'Connell	0-2.5	0-2.5	145-150	105-110	623	555	31	0
Sean OKelly	0-2.5	0-2.5	200-205	150-155	942	796	6	0
Tracey Nutter	0-2.5	0-2.5	150-155	115-120	682	592	72	0

* Please note that these tables have been subject to audit.

** Mr C Ridley is a member of the 2008 pension scheme and therefore the benefits are calculated at age 65 years.

Notes to Remuneration and Pension Tables

As Non-Executive directors do not receive pensionable remuneration, there are no entries in respect of any pensions.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pensions benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures show the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase on CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement). The factors used to calculate the 2012 CETVs have increased; therefore the value of CETVs for some members has increased by more than expected since 31 March 2011.

Median Remuneration that Relates to the Work Force

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median

remuneration of the organisation's workforce. The mid-point of the banded remuneration of the Trust's highest paid director in 2011-12 was £162,500 (2010-11, £167,500). This was 7.3 times (2010-11, 7.7 times) the median remuneration of the workforce, which was £22,400 (2010-11, £21,800). In 2011-12, 1 (2010-11, Nil) employee received remuneration in excess of the highest paid director. Remuneration ranged from £6,600 to £167,000 (2010-11 £11,600 - £167,000). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The pay multiplier between the median remuneration of the workforce and the highest paid director fell in 2011-12 due to an in year change of Medical Director. Based on annualised pay, the Medical Director was the highest paid director in both years. Please note that this information has been subject to audit.

Trust Board Employment Terms

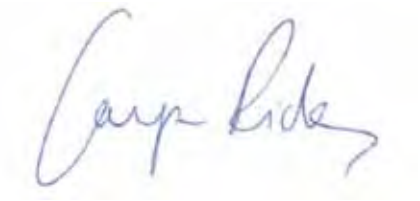
The Chairman and Non-Executive Directors of the Trust are appointed by the Council of Governors for a term of office of up to four years. This can be renewed for a second four year term with the agreement of both parties.

The appointment of the Chief Executive is made by the Non-Executive Directors and approved by the Council of Governors. The Chief Executive and Executive Directors have a contract with no time limit attached and the contract can be terminated by either party with three-month's notice (six months in the case of the Chief Executive). The contract is subject to normal employment legislation.

Executive Directors are appointed by a committee consisting of the Chairman, Chief Executive and Non Executive Directors.

The Trust's Constitution sets out the circumstances in which a Director will be disqualified from office and employment terminated.

No significant awards have been made to past senior managers.



Caspar Ridley
Chief Executive
25 May 2012

NHS Foundation Trust Code of Governance

Disclosure Statement

The Trust Board has overall responsibility for the administration of sound corporate governance throughout the Trust and recognises the importance of a strong reputation.

In September 2006, Monitor, the independent regulator for Foundation Trusts, first published the NHS Foundation Trusts Code of Governance, which was updated on 1 April 2010. This Code builds on the Combined Code of Corporate Governance, which itself is the product of multiple corporate governance developments in the UK over many years.

The Trust Board supports the ideals and the ethos behind the Code and has reviewed the performance of the Trust against the main and supporting principles and provisions.

The way in which the Board applies the principles and provisions is described in the various sections of the report and the Directors consider that for the 2010/2011 year the Trust has been compliant with the Code with the exception of the following:-

C.2.2 – Appointment of Non Executive Directors for terms of no more than three years.

The Trust Board and the Council of Governors agreed that appointment of Non- Executive Directors should be for a term of four years in line with the constitution approved by the Regulator prior to authorisation as a NHS Foundation Trust on 1 June 2006

Details on the NHS Foundation Trust Code of Governance can be found on the Monitor website at www.monitor-nhsft.gov.uk

Statement Explaining How the Board of Directors and the Council of Governors Operate, Including a High Level Statement of Which Types of Decisions are Delegated to the Management by the Board of Directors

Board of Directors

The Board of Directors comprises the Chairman, Chief Executive, and six Non-Executive Directors and five Executive Directors, making thirteen in total. The Board meets on the first or second Monday of each month. Normally, six of the meetings are held in public and six in private. The public and private meetings alternate. The dates of the public meetings are advertised on the Trust's web-site and in the local press.

The Agendas, Papers and Minutes of all public meetings are published on the web-site and are also available in hard copy on request.

The Directors have collective responsibility for:-

- Following regulatory guidance such as Monitor , Care Quality Commission
- Setting strategic direction, ensuring management capacity and capability, and monitoring and managing performance
- Providing leadership and governance to the Trust within a framework of prudent and effective controls
- Providing accountability to Governors and being responsible to members and stakeholders
- Understanding and managing the operational, business and financial risks to which the Trust and its related businesses are exposed
- Monitoring the work undertaken and the effectiveness of the formal sub-committees of the Board
- Allowing flexibility to consider non-routine matters or items that are outside of the planned work programme
- Reviewing the performance of the senior management team

Annually the content of the agendas and the terms of reference of the Trust Board sub committees for the following twelve months are agreed to ensure there is a good order and appropriate timing to the management of the above functions.

The Board is required to comply with its Standing Orders, Standing Financial Instructions and the Terms of Authorisation as issued by Monitor, the Independent Regulator for Foundation Trusts. The Board has to submit an Annual Plan to Monitor and quarterly reports to confirm compliance with both the Trust's Financial and Governance targets and its terms of authorisation. The Trust was registered by the Quality Commission without conditions on 1 April 2010. The Board's role is to ensure ongoing compliance with the regulations.

Council of Governors

The Council consists of 25 Governors:

- 1 Patient Governor
- 14 Public Governors
- 6 Staff Governors
- 4 Nominated Governors

The Chair of the Trust Board is also the Chair of the Council of Governors and is the conduit between the two bodies. The full Council of Governors meets in public four times a year and also holds an AGM. The Chief Executive normally attends the Council meetings to present a performance report and respond to questions.

Non-Executive Directors attend by invitation on a rota basis to develop their own understanding of the work of the Governors and their issues.

The work of the Governors is divided between their statutory and non-statutory duties.

The statutory duties are to:-

- Set the Terms and Conditions of Non-Executive Directors together with their remuneration and allowances
- Appoint or remove the Chairman and Non-Executive Directors of the Trust
- Approve the appointment of future Chief Executives
- Appoint or remove the Trust's External Auditor
- At the AGM consider the Trust's annual accounts, auditor's report and annual report
- Be consulted by the Board of Directors on the development of forward plans for the Trust and any significant changes to the health care provided.

Where appropriate Governors have been placed, on a voluntary basis, on to Committees or into Groups to look at the requirements of these functions and present recommendations for the full Council to consider. On the non-statutory side the Governors have been placed into groups to consider various topics over which they can have an influence. In 2011/2012 these covered:

- Communications and Membership
- Communicating with members
- A Commentary to the Care Quality Commission
- Performance of Chairman and Non Executive Directors
- The Trust's Annual Plan for 2011/2012 prior to submission to the regulator
- Patient experience
- Staff membership growth and communications
- Governor's self assessment
- The strategic direction of the Trust
- Volunteers

The Governors review their work programme and the make-up of their working groups annually. They appreciate that, statutory roles apart, their principal duties are to monitor, advise and inform. The Board of Directors understands it is accountable to the Council of Governors.

Decisions Delegated to the Management by the Board of Directors

The Scheme of Delegation, which is included within the Trust's Standing Orders, sets out the decisions which are the responsibility of the Board of Directors. These are actioned either by the Trust Board or a committee of the Board.

Below Trust Board level the Executive Directors have established the Joint Board of Directors which consists of the Executive Directors, Clinical Directors and other senior post holders. The Joint Board of Directors meets monthly and is chaired by the Chief Executive. Its remit is to consider the management of the day to day business of the Trust, both operationally and clinically. The Joint Board of Directors is supported in its work by the Operational Management Board chaired by the Chief Operating Officer and the Clinical Management Board chaired by the Medical Director.

The Council of Governors

The Council of Governors is made up of elected and nominated Governors who provide an important link between the hospital, local people and key organisations - sharing information and views that can be used to develop and improve hospital services.

There are seven public constituencies that have been created to cover the Trust's general and emergency catchment area using local government boundaries. The Trust's public constituencies are called Salisbury City, South Wiltshire Rural, New Forest, Kennet, West Wiltshire, North Dorset and East Dorset. Governors from these areas are elected by members from these constituencies in strict accordance with election rules stated in the Trust's constitution using the 'First Past The Post' voting system. Elections are carried out on behalf of the Trust by the independent Electoral Reform Services Ltd.

In addition, there are elected staff Governors split into six staff groups and Governors who are nominated by partner organisations that have an interest in how the Trust is run. These are Wessex Community Action, a body that provides an over-arching voluntary presence at local level; Wiltshire Council that provides the main local authority link; NHS Wiltshire and NHS Dorset which are two of the main health commissioning bodies for the Trust.

The public and patient constituencies must make up at least 51% of the total number of Governors on the Council of Governors.

In addition to the AGM, and the joint meeting with the Trust Board to review the Annual Plan, the Trust hosted four meetings of the Council of Governors during the 2011/2012 year.

Elected Governors – Public Constituency

Name	Constituency	Date Elected	Term of Office	Attendance from 4 meetings
***John Carvell**	Salisbury City	May 2009	Three years	4
Celeste Collins	Salisbury City	May 2011	Three years	3
Chris Wain	Salisbury City	May 2009	Three years	4
Kate Beaumont	South Wiltshire Rural	May 2009	Three years	2
Robert Coate	South Wiltshire Rural	May 2009	Three years	4
****Dr Alastair Lack**	South Wiltshire Rural	May 2011	Three years	3 from 3
***Dr Beth Robertson (Lead Governor)**	South Wiltshire Rural	May 2009	Three years	3
Sara Willan	South Wiltshire Rural	May 2009	Three years	4
Paul Goldman	North Dorset	May 2011	Three years	4
Mary Hutcherson	North Dorset	May 2009	Three years	3
Wayne Arnett	New Forest	May 2009	Three years	2
John Markwell	Kennet	May 2009	Three years	3
Carole Noonan	West Wiltshire	May 2009	Three Years	4
Elizabeth Connock	East Dorset	May 2009	Three years	3

*Dr Beth Robertson replaced John Carvell as Lead Governor in June 2011 following the completion of John Carvell's two-year term of office
**Dr Alastair Lack replaced Chris Horwood following elections in May 2011

Elected Governors - Patient/Carer Constituency

Name	Constituency	Date Elected	Term of Office	Attendance from 4 meetings
Andrew Farrow	Patient/ Carer	May 2009	Three years	3

Elected Governors - Staff Constituency

Shaun Fountain	Medical & Dental	May 2009	Three years	3
Colette Martindale	Nurses & Midwives	Nov 2009	Three years	4
Lynda Weeks	Hotel & Property Services	May 2009	Three years	3
Louise Arnett	Clerical, Administrative and Managerial	May 2009	Three years	3
***Christine White**	Scientific, Therapeutic & Technical	May 2011	One year	1 from 3
Eric Gould	Volunteers	May 2009	Three years	3

* Christine White was elected in May 2011 for the balance of a three year term following the resignation of Nick Cross on 31 December 2010.

Nominated Governors

Name	Constituency	Date Elected	Term of Office	Attendance from 4 meetings
Anita Pheby	Wessex Community Action	May 2011	Three years	3
William Moss	Wiltshire Council	May 2011	Three years	3
Lis Woods	NHS Wiltshire	May 2011	Three years	4
Elizabeth Stevens	NHS Dorset	May 2011	Three years	4

Please note that a register of interests is held in the Trust Offices. Information regarding the Governors' interests and whether they have undertaken any material transactions with Salisbury NHS Foundation Trust can be obtained by contacting John Williams, Head of Corporate Governance, Trust Offices, Salisbury NHS Foundation Trust, Salisbury District Hospital, Salisbury, SP2 8BJ.

Statement Setting out the Steps that the Members of the Board, in Particular the Non Executives, Have Taken to Understand the Views of Governors and Members

During the year the Directors have used a variety of methods to ensure that they take account of, and understand, the views expressed by Governors and members. The Council of Governors is chaired by the Chairman and these meetings are always attended by the Chief Executive who presents a performance report and answers questions. This is an opportunity for the Governors to express their views and raise any other issues, so that the Chief Executive can respond. Minutes of the meetings are shared with the Executive and Non Executive Directors who have the opportunity to pick up and action any points that are relevant to their areas. The minutes of all Governor's meetings and working groups are also made available to the Executive and Non Executive Directors. The Senior Independent Director and other board members attend the Council of Governor's meetings by invitation on a rota basis. Executive and Non Executive Directors also attend some of the Governor working groups. In addition, there was one joint meeting between the Trust Board Directors and Governors to consider the Annual Plan and progress on the development of the Salisbury District Hospital site.

The Trust Board is aware of the work carried out by the working groups and information is fed back to the Directors. The Directors attend constituency meetings and the annual general meeting and answer member's questions. The Trust Board meets bi monthly in public and, as part of its commitment to openness, Governors and members are invited by the Chairman to comment or ask questions on any issues that they may wish to raise at the end of the public session. A response is provided by the appropriate member of the Trust Board. Trust Board papers are made available on the website and Governors alerted so that these can be viewed prior to the meetings.

The Board of Directors

Statement about the Balance, Completeness and Appropriateness of the Board of Directors

The Board comprises the Chairman, Chief Executive, five other Executive Directors and six other Non-Executive Directors. There is a clear separation of the roles of the Chairman and the Chief Executive, which has been set out in writing and agreed by the Board. As Chairman, Luke March has responsibility for the running of the Board, setting the Agenda for the Trust and for ensuring that all Directors are fully informed of matters relevant to their roles. The Chief Executive has responsibility for implementing the strategies agreed by the Board and for managing the day to day business of the Trust.

All of the Non-Executive Directors are considered to be independent in accordance with the NHS Foundation Trust Code of Governance. While, on appointment, the Chairman has to meet the Code's 'test of independence' it does not, thereafter, apply to this role.

The Board considers that the Non-Executive Directors bring a wide range of business, commercial and financial knowledge required for the successful direction of the Trust.

The strategies developed at the time of the Trust's application for Foundation Trust status have been revised to meet the changing demands on healthcare providers. These will need further development now that the Health and Social Care Act 2012 has been passed. All Directors are equally accountable for the proper management of the Trust's affairs.

All Directors are subject to an annual review of their performance and contribution to the management and leadership of the Trust. In 2011/2012, the Board undertook a further an external assessment of the effectiveness of the Board as a whole.

At the present time the Board is satisfied as to its balance, completeness and appropriateness but will keep these matters under review.

Statement Setting Out that the Board of Directors Undertake a Formal and Rigorous Evaluation of its Own Performance and that of its Collective and Individual Directors.

In 2011/2012, the Trust engaged the Kings Fund to help the Board of Directors undertake the evaluation of the Board and its sub committees. This included observation of the Trust Board in public meetings and one-to-one interviews with the Trust Board and the Lead Governor. An action plan was agreed to address minor shortcomings and the findings of the report presented to the Council of Governors which is responsible for the appointment and reappointment of the Non Executive Directors.

Evaluation of the Chairman's performance is led by the Senior Independent Director. The Chief Executive and Non Executive Directors' performance is evaluated by the Chairman, while an evaluation of the Executive Directors' performance is carried out by the Chief Executive.

The Board of Directors

Luke March
DL – Chairman (Independent)

Luke March was appointed Chairman of the Trust on 1 January 2005 for a term of four years and reappointed by the Governors for a second four-year term on 1 January 2009. He has been a Non-Executive Director in the NHS since 1988, first in Winchester and later in East London, as Deputy Chairman of Barts and The London NHS Trust. In the commercial sector Luke has held senior management appointments at Lloyds TSB and BT and was Chief Executive of the Mortgage Board. More recently he was Compliance Director of the Royal Mail Group. Luke lives in Great Durnford near Salisbury.

Caspar Ridley
Chief Executive

Caspar Ridley joined the Trust as Chief Executive on 1 March 2012 from University Hospital Southampton NHS Foundation Trust, where he was Director of Strategy and Business Development. He has wide experience in both the private and public sectors, starting with Royal Dutch Shell in 1989 and held several senior posts before becoming Global Head of Public and Government Affairs at Syngenta, an international agribusiness, before taking up his NHS role in Southampton. Caspar lives in Winchester.

Nigel Atkinson
Non Executive Director (Independent)

Nigel Atkinson is a chartered accountant and retired corporate financier and a former Head of Listing at the London Stock Exchange with over 30 years experience of corporate finance. Mr Atkinson was appointed on 1 February 2007 for a term of four years and re-appointed for a second four year term on the 1 February 2011. He lives in Cholderton in Wiltshire.

Dr. Christine Blanshard
Medical Director

Christine Blanshard graduated in Medicine from Cambridge University in 1986 and has over 25 years NHS experience. She trained in East Anglia and London, and became a consultant gastroenterologist and general physician in 1998. She has undertaken a variety of managerial roles alongside her clinical work and before joining the Trust was Director of Strategy and Associate Medical Director at Homerton University Hospital NHS Foundation Trust. She lives in Winchester.

Dr. Lydia Brown MBE
(Vice Chairman and Senior Independent Director)

Lydia Brown joined the Trust on 1 November 2008 for a four year term. She is a qualified vet and former President of the Royal College of Veterinary Surgeons. She has considerable business experience and is now a Managing Director within a Norwegian aquaculture business. Lydia lives in West Gomeldon in Wiltshire.

Barry Bull
Non Executive Director (Independent)

Barry Bull joined the Trust on 1 January 2005 for a four year term and was reappointed for a second four-year term on 1 January 2009. He has experience of private industry having worked his way up to director level within the Unilever group. He currently works for a charity that supports older people. He lives in Verwood in Dorset.

Malcolm Cassells
Director of Finance and Procurement

Malcolm Cassells is a qualified accountant with extensive financial experience gained through over 35 years in the NHS. He held senior financial positions at Regional Health Authority and District Health Authority level, before moving to Salisbury in 1986 as Director of Finance. He lives in Winterslow in Wiltshire.

Alan Denton
Director of Human Resources

Alan Denton has over 20 years NHS experience having worked throughout this period at senior management level in the field of Human Resources. He has a Masters degree in Human Resources Management and joined the Trust in 1988 having previously worked in the mechanical engineering and construction industries. He lives in Blandford Forum in Dorset.

Ian Downie
Non Executive Director (Independent)

Ian Downie, who is Strategic Development Director of Serco group, joined the Trust on 1 November 2009 for a four year term. He has considerable management experience within the aviation industry and more recently through a number of roles within the Serco group. He lives in Gussage St Andrew in Dorset.

Stephen Long
Non Executive Director (Independent)

Stephen Long joined the Trust on 1 November 2008 for a four year term, having retired as Deputy Chief Constable of Wiltshire after 30 years service. He was a diversity champion within the constabulary and a national lead for Science and Technology. Stephen lives in Wilton in Wiltshire.

Peter Hill
Chief Operating Officer and Deputy Chief Executive

Peter Hill has a nursing background and before coming to the Trust in 1986 worked on wards and intensive care units in London and Newcastle. He has a Masters degree in Business Administration and has extensive senior management experience. Peter was Interim Chief Executive until Caspar Ridley took up his position. Peter lives in Salisbury in Wiltshire.

Tracey Nutter
Director of Nursing

Tracey Nutter joined the Trust in April 2003 from Southampton University Teaching Hospitals NHS Trust where she was Associate Nurse Director. She has over 28 years NHS experience having worked in key senior nursing posts in Newcastle, London and Southampton. She has a Masters Degree in Health Services Management from the University of Manchester and an International Masters for Health Leadership from McGill University in Montreal. She lives in Poole in Dorset.

Major General John Stokoe
CB CBE - Non Executive Director (Independent)

John Stokoe was a senior army officer who commanded 100,000 soldiers worldwide before he retired from the army in 1999. He has considerable board level experience and was a Divisional Managing Director in the BT Group until March 2011. John joined the Trust on 1 November 2008 for a four year term and lives in Ashmore in Dorset.

Jim O'Connell
Interim Chief Operating Officer (Between 25 July 2011 and 29 February 2012

Jim O'Connell is a former National Director of Leadership at the Department of Health and was a Regional Director of Workforce and Organisational Development at the NHS South Central Strategic Health Authority. He has provided additional executive level support as Interim Chief Operating Officer at several NHS Foundation Trusts and is now Chief Executive at Hinchingbrooke Health Care NHS Trust.

Dr Sean O'Kelly
Medical Director (Until 18 April 2011)

Sean O'Kelly joined the Trust in September 2009. He has over 20 years NHS experience in anaesthesia and intensive care. He has extensive managerial and clinical experience in Britain and America and before joining the Trust Sean worked at the Department of Health and the Great Western Hospital in Swindon. Dr O'Kelly left the Trust on 18 April 2011 to take up an appointment with University Hospitals Bristol NHS Foundation Trust.

Michele Romaine
Non Executive Director (Until 31 January 2012)

Michele Romaine, is a former director of production for the BBC and joined the Trust on 1 November 2009. She has considerable management experience through a number of senior positions within the media industry and more recently through her own media consultancy and left the Trust at the end of January to further her business interests.

At the end of the first term of office, the Chairman and Non Executive Directors are subject to an evaluation by the Governors Performance Committee, which will make a recommendation to the full Council as to their individual suitability to serve a second term.

The removal of the Chairman or a Non Executive Director of the Trust requires the approval of three-quarters of the members of the Council of Governors at a general meeting.

Appointment of the Vice Chairman and Senior Independent Director is reviewed annually.

Employment terms for Executive Directors can be found in the Remuneration report earlier in this report.

Board of Directors' Attendance

	Trust Board (7 meetings)	Audit Committee (4 meetings)	Remuneration Committee (4 meetings)	Finance Committee (12 meetings)	Clinical Governance Committee (6 meetings)
Luke March	7	N/A	4	12	N/A
Caspar Ridley	0 from 0	N/A	N/A	1 from 1	1 from 1
Nigel Atkinson	6	4	4	N/A	5
Christine Blanshard	3 from 3	N/A	N/A	N/A	4 from 4
Lydia Brown	6	4	4	N/A	6
Barry Bull	6	3	2	12	N/A
Malcolm Cassells	7	N/A	N/A	11	N/A
Alan Denton	7	N/A	N/A	N/A	N/A
Ian Downie	6	N/A	4	12	2 from 2
Clare Fuller	3 from 3	N/A	N/A	N/A	N/A
Peter Hill	7	N/A	N/A	11	5 from 5
Stephen Long	5	N/A	3	N/A	5
Tracey Nutter	7	N/A	N/A	2 from 4	6
Jim O'Connell	3 from 4	N/A	N/A	7 from 7	N/A
Sean O'Kelly	0 from 1	N/A	N/A	N/A	N/A
Michele Romaine	6 from 6	N/A	3	N/A	3 from 5
John Stokoe	7	3	4	11	N/A

A register of interests is held in the Trust Offices. Information regarding the Directors' interests and whether they have undertaken any material transactions with Salisbury NHS Foundation Trust can be obtained by contacting John Williams, Head of Corporate Governance, Trust Offices, Salisbury NHS Foundation Trust, Salisbury District Hospital, Salisbury, SP2 8BJ.

The Council of Governors understands the different process that should apply in the selection and appointment of a replacement Chairman and that the Chairman must not simultaneously be the Chairman of another Trust.

The Audit Committee

	Committee Role	Attendance out of four meetings
Nigel Atkinson	Chairman	4
Lydia Brown	Member	4
Barry Bull	Member	3
John Stokoe	Member	3

The Work of the Audit Committee in Discharging its Responsibilities

On 12 March 2007 the Audit Commission was appointed by the Council of Governors as the Trust's External Auditors for three years from 1 April 2007, with an extension for a further two years which was agreed in November 2009. In 2011/2012 the Audit Committee met on four occasions. Please note that from I April 2012 the Audit Commission is no longer able to compete for public sector business following new Government regulations and the Governors appointed a new external auditor KPMG.

On 31 May 2011 the Committee met to specifically review the Trust's draft financial statements for 2010/2011 together with the Head of Internal Audit (South Coast Audit) Opinion Statement and the Governance report prepared by the Audit Commission prior to the submission of this documentation to the Trust Board on 6 June 2011 for final approval.

On 11 July 2011 the Committee received reports from the Audit Commission on their 'work in progress' and the findings presented in their Annual Management Letter for 2010/2011, subsequently presented to the Trust Board on 3 October 2011. Reports from the Internal Auditors, South Coast Audit, covered their conclusions on a range of Trust activities within their 2011/2012 work plan as agreed by the Committee while the Local Counter Fraud Specialist presented a summary of the work undertaken across the Trust to deter, prevent or detect fraud.

On 10 October 2011 the Committee again received update reports from the Audit Commission, South Coast Audit, the Local Counter Fraud Specialist and, additionally, reviewed the timetable for the preparation of the 2011/2012 financial statements as advised by Monitor, the Independent Regulator for Financial Trusts and, also, the management of the Assurance Framework and Risk Register. On 10 February 2012 the format and content of the meeting was similar to that of 10 October 2011.

At all meetings the Committee is particularly concerned to ensure the Trust has systems which:-

- Safeguard assets
- Maintain proper records
- Can produce reliable information
- Provide effective control systems
- Can be independently reviewed and assessed by both External and Internal Audit

The Director of Finance and Procurement, who has the Executive responsibility for liaising with both Audit functions, attends the Committee to comment and inform as required. The Minutes of all four meetings were presented to the Directors at the following public meeting of the Trust Board by the Chair of the Audit Committee, and subsequently made available for public reading on the Trust's website.

Financial Audit

The external auditors for the Trust are the Audit Commission. During the 2011/2012 period, the Trust has incurred the following costs on external audit:

- Audit services (statutory audit and reports to the Department of Health) £72,000
- Further assurance services: Nil
- Other services: Nil
- No post balance sheet events to report

As mentioned above, no other remuneration was paid to the auditor and the auditor was not involved in any other work that may have compromised its independence.

Directors' responsibilities for preparing the accounts

The Directors are aware of their responsibilities for preparing the accounts and are satisfied that they meet the requirements as reflected in the statement of Chief Executives Responsibilities as the Accounting Officer at Salisbury NHS Foundation Trust. This is can be found in the Annual Accounts for Salisbury NHS Foundation Trust.

Nominations Committee

During the year the Trust established two Nominations Committees (NCs). The first for the appointment of a new Medical Director, the second for a new Chief Executive. In both cases the Trust used an external search consultancy to help the committees. The committees reviewed the job descriptions, personal specifications and the candidate briefs, which were then used by the consultancy to promote awareness of the roles which were also advertised on the NHS Jobs website. A list was established with recommendations, which the committees reviewed and established a shortlist. In both cases an interview and two-day assessment took place to choose the successful candidates.

The nominations committee for the appointment of a Medical Director

	Committee Role	Attendance out of four meetings
Luke March	Chairman	4
Peter Hill	Member	4
Michelle Romaine	Member	4
Steven Long	Member	4
Steve Smith ***Northern Devon Healthcare NHS Trust***	External Advisor	4

The nominations committee for the appointment of a Chief Executive

	Committee Role	Attendance out of four meetings
Luke March	Chairman	4
Ian Downie	Member	4
Michelle Romaine	Member	4
Beth Robertson	Member	4
Robert Coate	Member	4
Jean O'Callaghan ***Dorset County Hospital NHS FT***	External Advisor	4

Membership

The Trust has traditionally had strong links with the local community, attracting around 560 volunteers and many more who take part in patient and public involvement activities. It has an excellent response rate for annual patient surveys and receives regular correspondence from grateful patients, highlighting the affection and interest local people have for Salisbury District Hospital.

The membership is made up of local people, patients and staff who have an interest in healthcare and their local hospital and these are broken up into three groups with different eligibility criteria.

Public Members

These are members of the public aged 16 and over who live in the geographical area outlined in the map.

Public members are placed in constituencies based on where they live. There are seven constituencies that have been created to reflect the Trust's general and emergency catchment area and these are based on local government boundaries.

Patient and Carer Members

This is made up of people from outside the general and emergency service catchment area (or their carers) who have been treated by the Trust's specialist services since 1 January 2003. These are plastic surgery, burns, cleft lip and palate and spinal injuries. Entitlement to become a new member ceases three years after discharge.

Staff Members

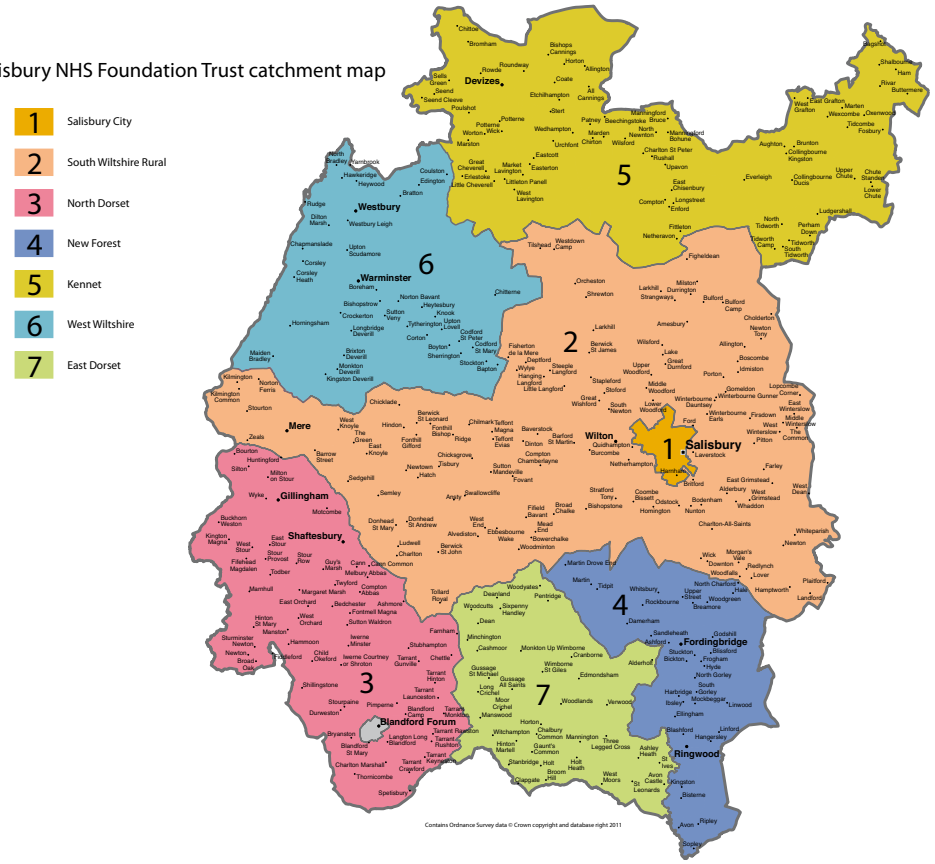
The Trust has a wide range of staff undertaking a variety of roles and professions who come from different backgrounds. The aim is that staff membership reflects that diversity. Initially staff membership was done on an 'opt in' basis rather than staff automatically being made members. During the 2008/2009 year, the Trust changed its policy and new members of staff who are eligible now automatically become members, with the option to 'opt out'. Eligible staff members are defined as those who:

- Hold a substantive contract of employment in excess of 12 months
- Hold a fixed term contract in excess of 12 months
- Hold a temporary contract in excess of 12 months
- Hold an honorary contract in excess of 12 months

The staff membership has six classes to reflect the following occupational areas:

- Medical and dental
- Nurses and midwives
- Scientific, therapeutic and technical
- Hotel and property services
- Clerical, administrative and managerial
- Voluntary

Salisbury NHS Foundation Trust catchment map



Patient and public members can only be a member of one constituency. Staff members can only be a member of the staff constituency. Members are able to vote and stand in elections for the Council of Governors, which is chaired by the Chairman of the Trust.

During the year the Trust sought to increase membership numbers. At 31 March 2012 the membership for Salisbury NHS Foundation Trust was as follows:

Public Constituency	**Number**
Salisbury City	2,816
South Wiltshire Rural	4,886
Kennet	1,635
North Dorset	1,842
East Dorset	968
New Forest	1,388
West Wiltshire	1,263
Patient/Carer Constituency	838
Staff Constituency	2,801
Total	**18,437**

Ownership of the Trust's membership strategy rests with the Governors with support from the Trust. The strategy was reviewed and updated in March 2009 and is currently in the process of being reviewed. This will help ensure that membership involvement is encouraged in the Trust's governance and decision making process, and that services continue to meet the needs of local people. Another objective of the strategy is to ensure that the membership continues to grow and is representative of the population by geography, age, ethnicity and gender.

The Trust uses information from the Office of National Statistics (Census 2001) to build up a picture of the population size and ethnicity for each constituency. This helps the Trust in its aim to make the membership reflective of its population, and also to ensure that the number of Governors is representative of the population of the constituencies. Having built up a membership database of 18,437 members at 31 March 2012, the Trust regularly reviews the age, ethnicity, gender and geographical spread to ensure that the membership is reflective of the whole area that it serves.

The Trust has also determined the socio-economic breakdown of its membership and the population within its catchment area.

Membership Size and Movements		
Public Constituency	**2011/2012**	**2012/2013 (estimated)**
At year start (1 April)	14,195	14,798
New members	818	657
Members leaving	215	250
At year end (31 March)	**14,798**	**15,205**
Staff Constituency		
At year start (1 April)	2,399	2,801
New members	532	229
Members leaving	130	150
At year end (31 March)	**2,801**	**2,880**
Patient Constituency		
At year start (1 April)	1,406	838
New members	0	100
Members leaving	568	23
At year end (31 March)	**838**	**915**
Overall Total	**18,437**	**19,000**

The Trust used its in-house database to monitor and increase the membership in line with demographic and statistical information and continued to use induction as a membership gathering point for staff.

This year the Trust used its public meetings to highlight the benefits of membership and encourage recruitment and these took place for the South Wiltshire Rural and Salisbury City constituencies in the 2011/2012 year. Members' newsletters were also used to encourage existing members to promote membership amongst friends and acquaintances and Governors continued to use their 'Are You a Member' campaign to recruit members in outpatient clinics.

This year the Annual Review went to over 140,000 households. This brought the work of the Trust and its staff to a wide audience and again highlighted the benefits of membership. Governors have been working in groups on their statutory duties and have also been involved in the development of the Trust's Annual Plan. They have been working on patient and public involvement initiatives. For instance, End of Life Care and Dementia Care. The End of Life Care Group covers a wide range of work which includes dedicated education and training for staff, and greater support and assistance for families where patients prefer to die at home. The Dementia Care Group has made significant improvements which have been covered in more detail earlier in this report.

Governors have also been involved in Patient Environment Action Team (PEAT) inspections, which look at cleanliness and food quality and are also on the Transport Strategy Group which looks at a range of areas such as green travel, signage and car parking. Another group is looking at food and nutrition in the hospital and Governor's have joined catering managers on unannounced visits to check food quality and temperatures at ward level.

Governors are also given a number of other opportunities to become involved or sample the 'patient's experience'. For example, Governors and volunteers visit wards and outpatient areas gathering instant feedback from patients about their hospital stay, which enables ward staff to resolve issues quickly. Around 1,700 patients last year were asked their views in this way.

The Trust continues to work with Governor Membership and Communication groups on a range of communication initiatives. A dedicated section on the Trust's website and Intranet provides details of each Governor, their interests and a means for members to communicate with them. There are also member's newsletters for staff and people in the public and patient/carer constituencies. Further opportunities are planned for Governors to meet their members formally in the 2012/2013 financial year.

Quality Report

PART ONE

Our Commitment to Quality - Chief Executive's View

Having recently joined the Trust I can see that we have continued to make progress over the last year in so many areas that affect the quality of care that we give to our patients, their families and visitors. This is reflected in a number of positive improvements. These include better access to specialist advice for GPs to avoid patients being unnecessarily admitted to hospital, more training for staff to help care for people with dementia and greater relief from discomfort for people who are coming to the end of their life. The Trust has also continued to maintain high standards of cleanliness and reduced the number of grade 3 & 4 pressure ulcers. However, we were reminded in 2011/2012 of the importance of maintaining our focus on infection prevention and control.

High quality care is the key priority for the Trust and the Trust Board is committed to improving quality through a 'whole organisation approach'. The Trust developed a 'trigger tool' for each service, which is a method that enables teams to self assess against key quality performance criteria. This helps the Trust and Directorates focus on key areas for improvement.

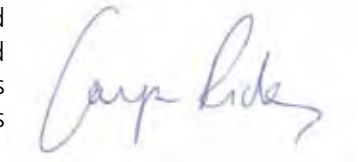
The Trust also uses clinical audit results, patient feedback and information from complaints and safety reports. These show where improvement is needed. For example all wards develop an action plan based on feedback from their patients. Quality of care is also included in Directorate level plans and reporting processes. It is measured as part of Directorate service reviews, and mid and end of year reports. The Trust uses Executive led 'walk rounds', which enable staff and patients to talk directly with members of the Trust Board and raise any quality or safety issues in their own areas with them. This also enables each service to review its own performance.

Quality is monitored regularly by the Board through a number of quality measures and indicators. For instance, the Trust Board receives a quality indicator report every month and a patient story is heard at every Clinical Governance Committee. These stories may have come from complaints, incidents or from service improvement projects. The quality indicators and patients' stories ensure that the Trust keeps focused on the things that are important to our patients. Patients and staff are also involved in service improvement events that cover their own areas. A good example of this can be seen in cardiology and orthopaedics, where staff have been working with the Kings Fund Point of Care Programme and the Health Foundation in a opportunity to use tried and tested methods to improve both processes of care and staff-patient interactions.

While the Trust Board has overall responsibility for quality, safety and patient experience, leadership for these areas is delegated to the Director of Nursing and the Medical Director.

Our emphasis on Quality will continue through a number of priorities for 2012/2013. Views and comments from clinical staff, local people, commissioners and the Trust's Governors have been used in the development of these priorities which will be addressed later in the Quality Account. Our staff work hard to provide excellent standards of care, and constantly assess their practices in order to make any changes that could benefit their patients. On behalf of the Board, I want to thank them for their hard work and professionalism in 2011/2012 and the positive contribution they make to the Trust and our patients.

To the best of my knowledge the information in this document is accurate.



Caspar Ridley
Chief Executive
25 May 2012

On behalf of the Trust Board
May 2012

PART TWO

This section provides a review of the progress we have made in our 2011/2012 priorities as published in the last Quality Account and sets out our priorities for 2012/13.

The priorities in 2011/2012 were:

Priority 1
Continue to improve the quality of end of life care for patients.

Priority 2
Ensure patients' privacy and dignity is maintained during their stay and improve responsiveness to their needs.

Priority 3
Further reduce the average length of stay for all inpatients by 10%.

Priority 4
Increase the percentage of patients who rate the quality of care they receive in hospital as very good or better.

Priority 5
Continue to keep patients safe during their stay in hospital.

Our priorities for quality improvement in 2012/2013 and why we have chosen them

Looking forward to 2012/2013 we have used a broad range of methods to gather information and determine our quality priorities. These include gathering patient real-time feedback which tells us how patients' experience care during their hospital stay. Information from the national inpatient and outpatient surveys are used and themed alongside comments, compliments, concerns and complaints to identify trends. We have also used risk reports and listened to what staff have told us during Executive Safety and Quality walk rounds. These rounds give staff the opportunity to talk face to face about safety or quality concerns with Executive Directors and Non-Executive Directors. These have helped us decide where we need to focus our quality improvement.

The priorities have been discussed with clinical teams as part of the service planning process. We have consulted widely on the priorities and involved the Foundation Trust Governors, staff, and engaged with local groups such as Age UK and local authorities, such as Wiltshire Council, North Dorset District Council and Wiltshire Involvement Network (WIN) to help us make the final decisions on our priorities for 2012/2013. Our commissioners, local GPs and the newly emerging Clinical Commissioning Groups have helped us determine our priorities and the work we need to do together. Some of their comments are included in this report.

The Trust has made good progress on last year's priorities however there are still further improvements that can be made and additional work areas have been identified for 2012/2013. A number of these areas are required for our CQUIN programme (Commissioning for Quality and Innovation) and support the CQC (Care Quality Commission) regulations.

As part of the NHS reforms a new NHS Outcomes Framework 2012/2013 has been published which focuses on patient outcomes and experience. The framework sets out five domains where health improvement can be achieved over a number of years. These domains are:

Domain 1	Preventing people from dying prematurely.
Domain 2	Enhancing quality of life for people with long term conditions.
Domain 3	Helping people to recover from episodes of ill health or following injury.
Domain 4	Ensuring that people have a positive experience of care.
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm.

Next year the Trust will be required to report on our performance against these domains. We will explore ways of developing new indicators to show patient outcomes in our next Quality Account in 2013/2014

Our priorities for 2012/2013 are:

Priority 1
Continue to improve the quality of end of life care.

Priority 2
Ensure patients' privacy and dignity is maintained during their stay and improve responsiveness to their needs.

Priority 3
Enable patients to receive timely and effective hospital treatment.

Priority 4
Ensure patients rate the quality of care they receive in hospital as very good or excellent.

Priority 5
Continue to keep patients safe during their stay in hospital.

Progress in these priority areas will be monitored through the Trust's quality governance process. To enable the Trust Board and Clinical Management Board to do this they will receive monthly reports and ask for further work where quality improvement is needed. The Trust Board minutes and reports can be viewed on the Trust website.

Both the Director of Nursing and the Medical Director have responsibility to lead in these priority areas.

The following sections describe the work undertaken in 2011/2012 to achieve or improve the priority areas.

Priority 1

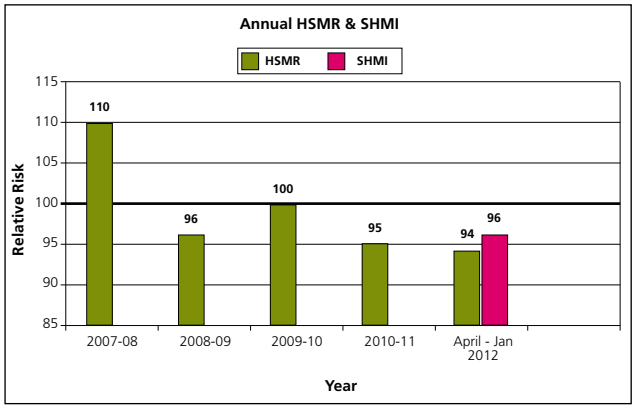
Continue to improve the quality of end of life care for patients

Description of the issue and reason for prioritising it:

The Trust has continued its work to reduce the number of deaths in hospital. We have done this by monitoring the HSMR (Hospital Standardised Mortality Ratio) and the actual number of deaths.

HSMR is an indicator of health care quality and safety which measures whether the death rate in a hospital is higher or lower than expected. If higher than expected this prompts further investigation so that learning is achieved and further improvements can be made. The national HSMR is set at 100. This means that an HSMR under 100 is better than average. Our HSMR for 2011/2012 was 94, so better than expected. HSMR are complex indicators and there has been international debate over how they should be calculated and used. To help hospitals better understand trends associated with patient deaths a new method called the Summary Hospital-Level Mortality Indicator (SHMIs) was introduced in 2011. Our SHMI from April 2011 to January 2012 was 96 so there is little difference between the two measures.

Current status



HSMR per year from 2007/2008 to 2011/12
SHMI was introduced in 2011

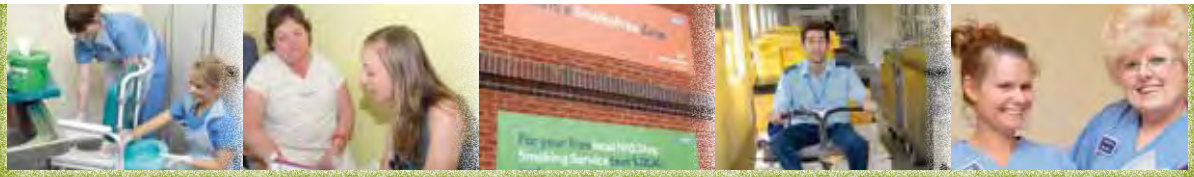
As well as reducing mortality rates, patients, carers and their families have told us that it is important to ensure they receive high quality care as they approach the end of life and that they have a choice of where to be cared for and where to die. Keeping patients and their families involved and informed is a crucial part of this.

What our patients and the public told us:

Relative – 'The staff accommodated Dad's large family as we all visited him to share happy memories and say goodbye'.

Relative – 'I really appreciated being able to spend time in a quiet space with my relative in the bereavement suite. The little things helped like having a dedicated parking space outside the suite'.

Husband – 'There were problems getting care set up at home for my wife to come home to die'



What we did last year to support this improvement priority:

- Last year we said we would roll out the mortality review tool to all clinical teams and we have done this with the majority of teams. A common theme arising from these reviews has been a lack of communication with the patient or their family when staff recognised that the patient was deteriorating or dying. Hence, we said we would introduce a staff education programme. We have done this for ward based teams and senior doctors who work alongside the hospital chaplaincy team. Topics include assessment and recognition of the dying patient, breaking bad news sensitively, how to have difficult conversations, how to offer effective pain management and symptom control, meeting spiritual and individual needs and supporting families and carers.

- We said we would develop effective ways of identifying the patient's preferred place of care and death. We have done this by working with local GPs to ensure we meet each patient's end of life care wishes so that plans are put in place in good time.

  Last year we said we would take action to improve discharge in a timely manner. We have made progress in setting up a rapid discharge process for patients who would prefer to die at home. This ensures that staff have talked to patients and families about their wishes, carried out prompt assessments and ensured transport and equipment is provided at the right time through close working with community teams.

Our bereavement team have surveyed relatives and carers asking them about their experience of using our bereavement service. The results were very positive. Relatives felt able to visit the suite when it was convenient for them and were given accurate information about what to do following a death. They also found staff helpful and supportive. However, some visitors found the suite difficult to find. As a result new, easy read signage was installed to improve directions for bereaved families. Our bereavement service received excellent scores in the annual Patient Environment Action Team (PEAT) review.

We took part in the third round of The National Care of the Dying Hospitals Audit. This showed that, when needed, all the wards in the hospital use national guidance known as 'the care of the dying pathway'. Its use is considered best practice and ensures that patients, relatives and carers receive the best possible care in the last hours or days of life.

The audit also showed we had improved the prescribing of medication for key symptoms such as pain, sickness and agitation. However, it showed we needed to improve the completion of 'the care of the dying pathway'. The results also showed we had improved communication with relatives or carers, so they knew what was happening and what to expect next.

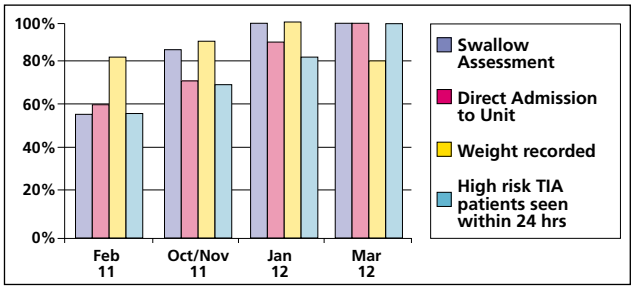
The table below shows our results of the 2nd and 3rd round of the National Care of the Dying Audit compared to the national average.

Key performance indicators	Salisbury District Hospital 2008/2009 (2nd round)	National compliance 2008/2009 (2nd round)	Salisbury District Hospital 2011 (3rd round)	National compliance 2011 (3rd round)
Proportion of wards using the care of the dying pathway	94%	75%	100%	90%
Prescribing for key symptoms such as pain, agitation and sickness	78%	88%	92%	83%
% compliance with completion of the care of the dying pathway	62%	74%	60%	67%
Communication with relatives or carers regarding the plan of care to promote understanding	34%	60%	67%	71%

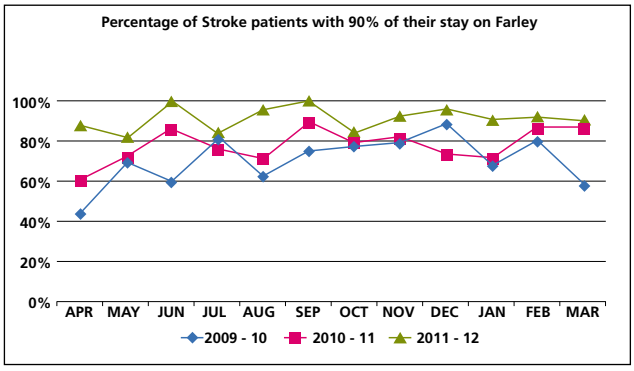
- We said we would develop quality indicator reports for the stroke and fractured hip service and use these in our improvement work.

We introduced a stroke key indicator report and made improvements in the following areas. We increased the percentage of patients having a swallow assessment by a speech therapist within 72 hours of admission from 58% to 100%. We also increased the percentage of patients we admitted to the stroke unit within 4 hours from 60% to 90% and increased the percentage of patients who spent 90% of their stay on the Farley Stroke Unit. For patients at high risk of a transient ischaemic attack (TIA) we increased the numbers investigated and treated within 24 hours. We achieved this by introducing a daily TIA clinic.

The following table shows the percentage improvement from February 2011 to March 2012 of stroke patient care for four key stroke indicators.



The line graph below shows an improvement in the percentage of patients who spent 90% of their stay on the Farley Stroke Unit from 2009 – 2012.



We developed a hip fracture quality indicator report and submitted the information to the National Hip Fracture audit. Our results in 2011 showed that 74% of patients had hip fracture surgery within 36 hours of admission maintaining good progress from the previous year. The results also showed we had improved on the number and quality of pre-operative assessments carried out by a senior doctor who specialises in the care of older people with a fracture. The assessment rate by a senior doctor specialising in the care of older people increased from 1.5% in 2010 to 48.7% in 2011. The prescription of bone health medication to help prevent further fractures and falls assessment also showed improvement.

Since the National Hip Fracture audit report was published in 2011 the Orthopaedic team have continued to make improvements. In April 2012 they won a national award which recognised their achievements in meeting all six standards in 85% of hip fracture cases making the Trust the second best performing hospital in the country.

What will we do in 2012/2013?

- We will continue to work together with GPs to ensure we respect individual patient choice about where they want to die.
- We will continue to provide staff education so that they are able to care for dying patients and talk sensitively with them, their relatives and carers.
- For patients who prefer to die in hospital we will give compassionate, good quality care and maintain their privacy and dignity.
- For patients who wish to die at home or in a nursing home we will ensure they are able to leave hospital as soon as they can and that they have everything they need in good time. Our care teams will continue to work with community and social care partners to deliver care and support where patients and families need it.
- We will continue to work with clinical teams to ensure mortality reviews are held and ensure that lessons are learnt across the Trust.
- We will work with clinical teams to ensure we communicate clearly with patients and their families with regard to plans for their care.

How will we report progress throughout the year?

We will monitor our progress through the Trust's End of Life Care Strategy Steering Group and the Mortality Working Group. These groups report to the Clinical Management Board every six months and to the Clinical Governance Committee annually.

Priority 2

Ensure patient's privacy and dignity is maintained during their stay and improve responsiveness to their needs

Description of the issue and reason for prioritising it:

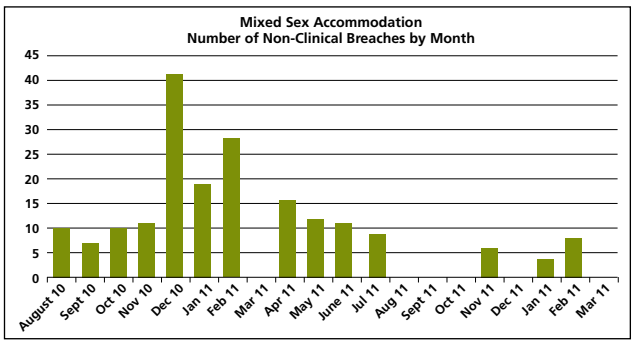
We expect all our patients to be treated with compassion, dignity and respect and with care that is personal to their individual needs. We have worked with local GPs, Age UK and Governors who have all told us that the care of older people, people with dementia and people with learning disabilities need to be key priorities. In particular giving priority to ensure that all patients have help to eat and drink, staff have time to meet relatives and all patients know what is happening in their care.

The Trust took part in the National Audit of Dementia which showed where we needed to make improvements. Areas where we need to focus our work include improved staff training on dementia, improved number of nutritional assessments completed, increase the number of patients seen by a mental health specialist and receiving a formal mental health test.

What we did to support this improvement priority:

- In last year's Quality Account we said we would continue to eliminate mixed sex accommodation and we have achieved this on most occasions in our ward areas.

The number of patients who shared accommodation with a member of the opposite sex can be seen in the following bar chart from August 2010 to March 12. It shows the improvement that has been made.



- Last year our Cardiology and Orthopaedic teams participated in a ground breaking new programme with the Kings Fund and Health Foundation called the Point of Care programme. Their research found that not all hospitals consistently provide compassionate care and we applied to be one of the five hospitals to take part in the pilot programme.

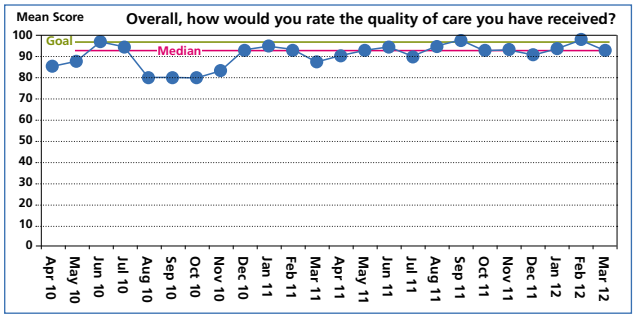
Our Cardiology team used this programme to improve the pathway of care for people who need diagnosis and treatment of heart disease. The following improvements were made after feedback from patients:

- Improvements to the privacy and dignity of patients in the waiting area. We provided a specific cardiology waiting area.
- We produced a DVD to explain what to expect during a cardiac angiography (examination of the vessels of the heart).
- Patients now stay in their own clothes during the procedure if they choose to.
- We give better more timely information – we put frequently asked questions on the website and have set up a telephone advice line so that patients can talk to a specialist nurse in private.
- We offer a separate room where patients can discuss their treatment away from the bedside.

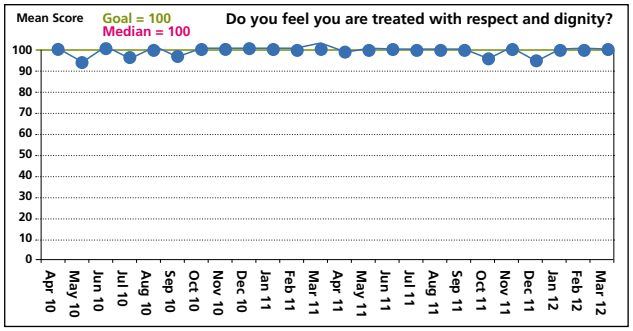
The Orthopaedic team made improvements to the way patients with fractured bones experienced inpatient care. The following changes were made.

- A greater emphasis was put on assisting patients at meal times and now the whole team are involved in serving food and helping patients to eat and drink.
- We introduced coloured crockery for patients with dementia which acts as a 'visual prompt' for them and encourages them to eat.
- We set up an activities club which is now run regularly. Patients also sit at the table to eat together at lunchtime.
- Patients at high risk of falls are seen by a nurse or carer at least every hour to ensure that they are comfortable and they have everything they need.

The Orthopaedic ward patient feedback graph shows from the start of the programme in April 2010 to the end of the programme in September 2011 patients felt that the quality of care they received had improved.



The Orthopaedic ward patient feedback graph shows that patients felt that their privacy and dignity had been sustained since the start of the programme in April 2010.



- We said we would work on the Learning Disability action plan developed following the regional peer review in 2010 and as a result we introduced a number of improvements. These included a Hospital Passport, which contains important information about the person which helps us to plan their care and make reasonable adjustments. The passport is filled out by them, their family or carers in the community.

  We set up Learning Disability training and awareness for staff together with a 'Top Ten Tips' poster which displays 10 key messages for staff when a patient with a learning disability is admitted to a ward.

- We said we would implement training on mental health needs. We have increased the number of staff who have completed Mental Capacity Act training. We have made better use of Independent Mental Capacity Advocates (IMCA) who support patients, without families, who are unable to make decisions about their care. This is demonstrated through a rising referral rate.

- We said we would complete a self assessment of dementia care against best practice guidance and develop and implement actions to make improvements in this area. We did this by setting up a Dementia Steering Group with membership from the hospital, community and social services, commissioners, the voluntary sector, Governors and a patient and carer involvement group. The group undertook an assessment of our compliance against the eight regional hospital standards for people with dementia and led the improvement work. Strong links have been established with local memory support and carers groups to ensure their experiences influence the improvement plan.

- There are now 55 dementia champions who provide support and advice for staff and patients. All staff now attend dementia training with additional support from the dementia champions.

- A leaflet called "Communicating with Someone with Dementia" was written for all staff and volunteers.

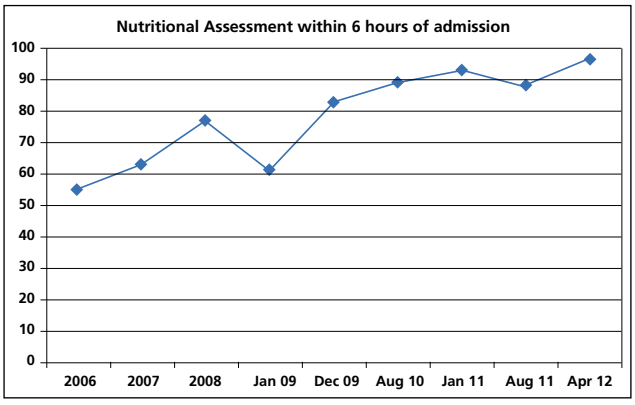
- Two documents that support staff called "This is Me" and "Caring for Someone with Dementia" are now widely available in the hospital.

- A mental health specialist nurse was appointed in 2011 to provide advice to staff on caring for people with dementia and works closely with the discharge team.

- Daily therapy and recreational activities have been introduced, such as an activities group and lunch club on Chilmark ward.

- Volunteers have started to attend training to help them support patients to eat and drink alongside staff.

- We have increased the number of patients who had a nutritional assessment and a nutritional plan. The line graph below shows the improvements made in nutritional assessment.



- In conjunction with the Alzheimer's Society, we introduced basic dementia awareness training. We also tested an advanced dementia course for dementia champions. End of life training in dementia care started in January 2012.

- We took part in the National Dementia Awareness week and Alzheimer's Awareness Day.

- In January 2012 we received a positive report on the care we provide to patients with dementia following a review carried out by specialists and carers from the South West region. The review team identified clear, strong, leadership and commitment and a positive culture within the Trust, which has enabled it to make significant changes over the last 12 months to improve the care for patients with dementia. The report also noted the enthusiasm and spread of dementia champions across clinical and non clinical areas who provide support and advice for staff and patients.
  The review team also found real commitment towards the nutritional standard, with well organised mealtimes and support for patients and good interaction between staff and patients.
  The report also helped to identify areas that could benefit from further improvement. These centred mainly on the creation of a dementia friendly environment with better use of 'orientation cues' such as easy-read clocks, calendars and coloured crockery.

What our patients and the public told us:

Relative – 'My husband has dementia. I really appreciated the Sister calling me at home. It kept me in touch and it gave me time to think in private and plan the next steps'.

Patient – 'I was very pleased with all the food I was given and ate everything with help'

Patient - 'I do not feel as involved as I want to be in what is happening'

Real time feedback from 2009 to 2011

Volunteers and Governors asked a random selection of patients throughout the year whether they felt they were treated with dignity and respect so that immediate action can be taken if patients have a concern.

The table at the foot of the page shows our performance in terms of the number and percentage of patients who felt they were treated with dignity and respect over the last three years.

Current status

National Inpatient Survey Questions	2008	2009	2010	2011
Were you involved as much as you wanted to be in decisions about your care and treatment?	56%	51%	54%	51%
During your stay in hospital did you ever share a room or bay with patients of the opposite sex? (Declining % is good)	18%	14%	11%	11%
Were you given enough privacy when discussing your condition or treatment?	74%	72%	72%	75%
Did you find someone on the hospital staff to talk to about your worries or fears?	36%	33%	40%	41%
Overall, did you feel you were treated with respect and dignity while you were in hospital?	81%	80%	81%	79%

Do you feel you are treated with dignity and respect?

	Sep 09 - Mar 10		Apr 10 - Mar 11		Apr 11 – March 12	
Yes, always	582	89.4%	1476	92%	1491	94%
Yes, sometimes	57	8.8%	117	7%	96	6%
Totals	**651**		**1606**		**1587**	

What will we do in 2012/2013?

- We will continue to work hard to eliminate mixed sex accommodation in our ward areas.
- We will introduce the identification and risk assessment of patients with dementia when they come into hospital and refer them on to their GP or specialist mental health services when appropriate to ensure that they receive effective care and treatment.
- We will continue to expand the use of colour including coloured crockery, easy read clocks, activity and lunch clubs which help give dementia patients a friendlier environment.
- The Artcare team will work with the staff on Winterslow ward to improve the day room to make it more comfortable for all patients.
- We will continue with our audits of observation at mealtimes and will involve senior staff and volunteers who are trained to help patients eat and drink at meal times.
- We will improve the nursing assessment documentation to better highlight those patients at high risk of malnutrition and how we are helping them.
- We will work with social care teams to improve the assessment of the needs of carers who are looking after people with dementia.
- We will improve access to the mental health specialist service for older people.
- We will continue to train our dementia champions and staff in dementia care.
- We will continue with the improvements we are making for patients with learning disabilities. For example, we will ensure we have systems in place to highlight patients' needs on our computer system so that important information is known before coming to hospital for an appointment. This helps us plan appointment times and better cater for patient preference.
- We will use the learning developed from the work with the Kings Fund and run the programme ourselves in Redlynch, an acute medical ward and Winterslow which specialises in the care of older people.
- We will expand the 'Young at Heart' creative time for older people on the wards. This involves activities such as singing, dancing, music and storytelling which provides physical and mental stimulation during the recovery phase and helps to lift patient's moods.

How will we report progress throughout the year?

We will monitor progress through the Dementia Steering Group, Learning Disabilities Working Group and Food and Nutrition Steering Group. They report to the Clinical Management Board every six months and to the Clinical Governance Committee annually.

Priority 3

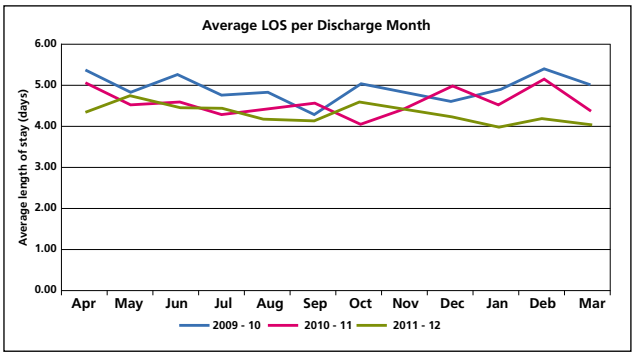
Further reduce the average length of stay for all inpatients by 10%

Description of the issue and reason for prioritising it:

The length of stay can vary between patients with similar conditions and the main reasons for delays can be the way in which we manage ward rounds and arrange tests and medicines. There can also be hold ups when patients are ready to be discharged because the necessary arrangements that need to be in place in the community are not always available.

Reducing length of stay and unnecessary admission to hospital are key features within the NHS reforms. We now have a real opportunity to make changes which will benefit our patients. Key to achieving this will be better management of their care while in hospital and providing care closer to home.

The graph below shows a reduction in the average length of stay for all patients discharged between April 2009 to March 2012.



What we did last year to support this improvement priority:

The Trust had a clinically led programme to improve the care people received from the moment they were admitted to hospital to their discharge.

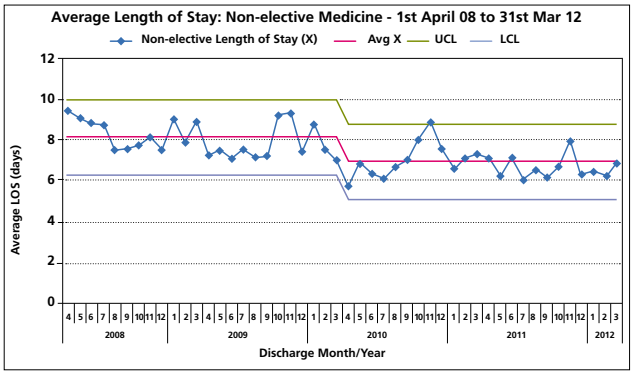
- Last year we said we would work with our GP and community partners to explore alternative models and settings for care for patients who do not need to be in hospital. Patients admitted to the Emergency Department who have difficulty with walking, washing and dressing for example are now seen by our therapy team who are available to support patients 7 days a week. Without this, these patients may have been admitted to hospital. We have also continued to increase the number of referrals to community care services where people can get appropriate support at home.

- We said we would continue to develop the Ambulatory Emergency Care model in admission areas providing patients with prompt tests, investigations, clinical assessment and avoiding admission. We have expanded the number of conditions for which patients can get rapid assessment, investigation, diagnosis, and treatment and the areas in which this is done including the Emergency Department, the Surgical Assessment Unit and the Medical Assessment Unit (MAU). For example, in the MAU, once a diagnosis is made a consultant will make a final decision as to whether a patient needs to be admitted to hospital for treatment or further investigations. On average 31% of patients do not need any further immediate attention and are able to go home within 12 hours. Some may be given an appointment to be seen again as an outpatient for further tests.

- Last year we said we would continue to reduce unnecessary delays in patients hospital stay. We introduced specialist team ward rounds on MAU for patients with conditions affecting their heart, breathing, diabetes and cancer problems. This enables patients to have a specialist treatment plan more quickly.

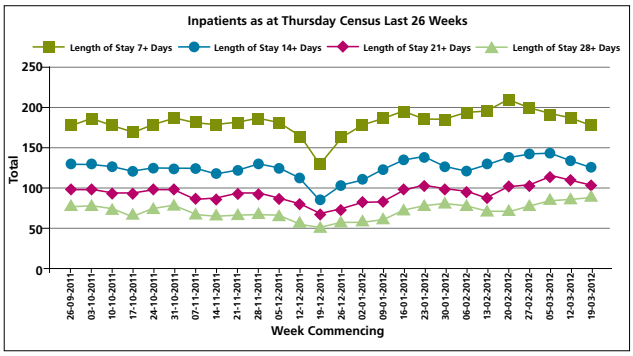
  Every patient is given an estimated discharge date that they are involved in deciding with their care team, family and carers. The patient's discharge plan is reviewed at 7, 14, 21 and 28 days to ensure that patients do not stay in hospital longer than is clinically necessary. Working with community partners this has had a direct impact on reducing length of stay up until Christmas 2011.

The table below shows a reduced average length of stay of emergency medical patients from 9.46 days in April 2008 to 7 days in March 2012.



UCL = Upper control limit LCL = Lower control limit

The table below shows how we have reduced the length of stay of emergency medical patients at 7, 14, 21 and 28 days between June 2011 to December 2011 but saw a rise in the New Year period when the hospital was at its busiest.



- We said we would develop our discharge team and improve processes. We have increased the number of discharge co-ordinators in the hospital who provide extra help for those with complex needs.

- Last year we said we would try and understand the reasons patients are re-admitted to hospital and work to reduce avoidable re-admissions. We know from audit data that 60% of readmissions are related to the original reason for admission. Some patients are re-admitted to hospital because they do not have the necessary support and information about their condition when they are at home. A good example of this are patients with long term breathing conditions who now have support of a community matron and are able to attend a rehabilitation programme to help them cope with their condition.

- Last year we said we would take action to improve discharge in a timely manner. We have made progress in setting up a rapid discharge process for patients who prefer to die at home.

This ensures that staff have talked to patients and families about their wishes, carried out prompt assessments and ensured transport and equipment is provided at the right time.

- We said we would extend the enhanced recovery programme. This is now used in colorectal, orthopaedic, urology, gynaecology and plastic surgery services. Involving patients and giving them clear information about the important role they have in the success of their speed of recovery. For example, knowing that they will be getting out of bed on the day of surgery and eating and drinking normally.

  In comparison to the national position we are the best in the country for length of stay for patients who have had a hysterectomy and colorectal surgery. Good progress has also been made for patients undergoing urology, plastic surgery and maxillo-facial surgery and hip replacement surgery.

Other clinically led programme has also been rolled out:

- Outpatient improvement programme – has seen a reduction in the number of patients not attending for booked appointments. We did this by reminding patients about appointments by text and booking follow up appointments nearer the time rather than months in advance.

What will we do in 2012/2013?

Priority 3

Enable patients to receive timely and effective hospital treatment

- We will continue to expand the number of conditions suitable for same day assessment and treatment so more patients can go home faster.

- We want to ensure that patients are involved in deciding their expected date of discharge (EDD) within 12 hours of coming in so that going home is focused around their needs.

- We want to focus on reducing the number of patients who have been in hospital for 14 days through a well planned treatment and discharge plan.

- We will move our social care team to work in the same place as the hospital discharge team. This will enable them to support patients with complex needs better and more quickly.

- We want to reduce the delays some patients experience who are medically fit to leave hospital but are waiting for a nursing home assessment.

- We will continue to work on ensuring patients are able to go home seven days a week. There will be a particular focus on weekend discharges in partnership with GPs and community services.

- We will introduce a mobile chemotherapy unit so patients can have their treatment closer to home.

- We will progress the enhanced recovery programme for knee replacement patients.

- We would like to reduce the time stroke patients spend in hospital through the use of an early supported discharge service.

- We want to introduce a self management plan for patients with long term breathing conditions so that when they start to feel unwell they can start medication early with the support of their community matron and so avoid hospital admission where possible.

- We will encourage diabetic patients to take their own insulin in hospital if they are able to do so in order to promote and maintain independence.

- We will introduce an alcohol screening programme for patients attending the Accident and Emergency Department. This will enable us to identify patients who may require advice and a referral to their GP.

What our patients and the public told us:

Patient – 'My discharge was planned and explained before surgery and happened just as they said it would. Text book'.

Patient – ' Pharmacy was excellent in the care they gave me prior to going home'

Patient – 'Discussion of care needs before discharge were not good'.

How will we report progress throughout the year?

- Progress against length of stay and other performance indicators are monitored by Directorate performance dashboards monthly and the Operational Management Board every 6 months.

Priority 4

Increase the percentage of patients who rate the quality of care they receive in hospital as very good or better

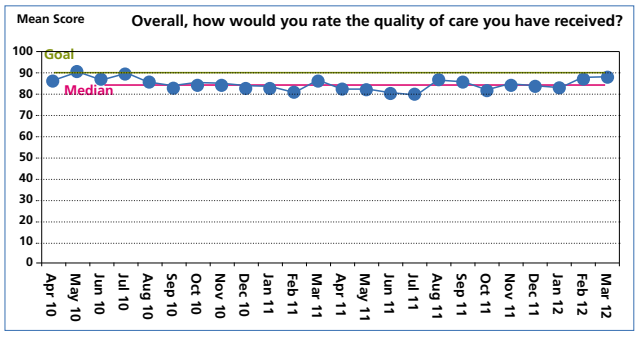
Description of the issue and reason for prioritising it:

It is important the Trust does everything it can to provide high quality care for all our patients and ensure care is effective, personal, safe and patients are treated with compassion, dignity and respect. Patients have told us that we do not get everything right every time and therefore we must find out what happened, learn from it, and work to improve care.

The table below shows the percentage of patients who rated their care as excellent or very good in the National Inpatient Survey from 2009 to 2011.

National Inpatient Survey question (% of patients who rated their care as excellent or very good)	2009		2010		2011	
Overall, how would you rate the quality of care you received?	363 out of 484	75%	425 out of 524	81%	412 out of 531	78%

The real time feedback chart below shows the mean score of patients who rated the quality of care they received in this hospital from April 2011 to March 2012.



We recognise that these results show we are not making improvements quickly enough in these areas. Further analysis of these results with patients tell us:

- Doctors and nurses do not always introduce themselves.
- They do not always know what is planned for their care and treatment.
- Call bells are not always answered promptly.
- Noise, especially at night is disturbing sleep.

What we did last year to support this improvement priority:

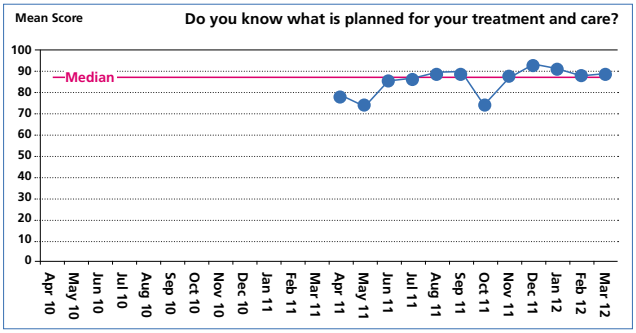
- We said we would continue our work on the Productive ward – releasing time to care programme which has been rolled out in all ward areas. Some initiatives from this programme have been staff handover at the patient's bedside which helps ensure patients are kept informed of their plan of care, specified times for medicine rounds without interruption and better organisation and assistance for patients at meal times.

- We said we would encourage relatives on all wards to discuss future plans with medical and nursing staff. Some wards have introduced a flexible appointment system so that time can be set aside for them to speak to a senior member staff without interruption. On other wards the nurse in charge is available 24 hours a day to talk to relatives. Information is made available to ensure patients and relatives know to ask.

- We said we wanted to make sure that information from the whiteboard meetings (these are brief daily meetings held with doctors, nurses, therapists and social workers to discuss patient progress and plans) are discussed with the patient so that they are fully involved in decisions about their care. Although this has been implemented, patients continue to tell us they do not always know what is planned for their care and treatment, so more work needs to be done to improve in this area.

- We said we would add a question to our real time feedback to ask patients whether they knew what was happening in their care and we did this.

The real time feedback chart below shows the mean score of whether patients knew what was planned for their treatment and care, from April 2011 to March 2012.



- We said we wanted to update ward routine information so that patients know what to expect on a day-to-day basis. This is done either through an information pack or a simple list given to the patient and their family when they arrive. Patients also have a verbal introduction and a tour of ward facilities, such as toilets and bathrooms.

- We said where patients felt call bells or noise at night were an issue, wards would have individual action plans and this was achieved. However, call bell response times continue to feature in our patient comments and are still not as good as we would like them to be and work is taking place to improve this. We worked with the Patients Association who undertook 'mystery shopping' to find out in more detail how response times could be improved. Their recommendations form part of each wards action plan.

What our patients and the public told us:

Patient – 'Very happy with the care I had'

Patient – 'I was treated very well during my stay in hospital'

Patient – 'I did not feel that I was involved in my treatment as I wished to be'

Patient – 'Sometimes the call bells were not answered for maybe 10 minutes which was very disturbing for sick patients'

What we will do in 2012/2013?

Priority 4

Ensure patients rate the quality of care they received in hospital as very good or better.

- We will spread the use of intentional rounding. This means high risk vulnerable patients will be seen by a nurse or carer every hour to ensure they are comfortable and they have everything they need.

- It is important our patients know what is planned for their care and treatment and so we will continue to make sure that information discussed and decided at the daily whiteboard meetings is discussed with the patient. We will monitor progress through real time feedback.

- Where patients have identified call bells and noise at night are an issue these will be included in ward action plans to ensure staff remain active in reducing noise. We want to try a new call bell system and pilot it on one medical ward. We will survey patients to find out the exact cause of noise especially at night. We will continue to work with an independent noise specialist to reduce environmental causes where possible.

- Where patients have told us staff do not introduce themselves or could be more welcoming we will ensure customer care training is provided.

- We will introduce a 'Patient Day' board on Farley Stroke Unit as a pilot project. This will explain the ward routine and will include the time the senior nurse 'matron' visits the ward, the times relatives can see staff and advertise the various social activities. For example singing, crafts and pat dogs.

- We will continue with improvement work in the Outpatient services to reduce wasted appointments and improve communication and information if patients are kept waiting.

How will we report progress throughout the year?

Real time feedback is reported to the Trust Board, Clinical Management Board, Operational Management Board and our commissioners monthly and every two months to the Clinical Governance Committee. The other work programmes will be reported through the Clinical Management Board and then to the Clinical Governance Committee.

Priority 5

Continue to keep patients safe during their stay in hospital

Description of the issue and reason for prioritising it:

The safety of our patients is a key aim in our quality improvement work. We have been actively engaged in a patient safety programme which has been co-ordinated at a regional level. Our aim is to reduce levels of harm to patients whilst in hospital and we measure this through things like pressure ulcer rates, infection rates, cardiac arrest calls, and the number of patients falling in hospital. All of these can lead to extra days or weeks in hospital, pain and distress for our patients. This fits with a national priority this year across the NHS to measure the incidence of pressure ulcers (sores), falls, urine infections from catheters, and venous thrombo-embolisms (blood clots) through what is called the Safety Thermometer.

Patients also continue to tell us that they want a clean hospital and that they do not want to get any infections during their stay with us. We shall, therefore, continue to focus on infection prevention and control as an important area of care.

What did we do last year to support this improvement?

We said that we would continue to take an active part in the regional patient safety programme; these are some of our achievements over the past year:

Leadership for safety:

- Executive Safety and Quality Walk Rounds continued throughout the year. Directors visit a different department each week to discuss safety and quality issues with the staff and patients.

Reducing Harm in Critical Care:

- The Intensive Care Unit continued to improve performance through the use of care bundles (which are a set of practices that when performed together improve patient outcomes) in order to drive down infection and have reported no MRSA blood stream infections since 2009. The Intensive Care Unit were also our first department to introduce the urinary catheter care bundle. This is a set of practices used together to reduce urine infections caused by the presence of a catheter.

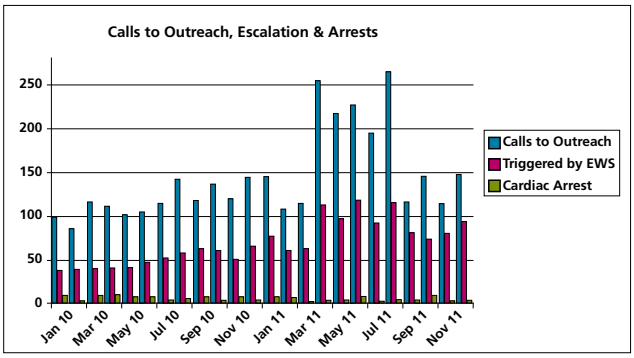
Reducing Harm in General Wards:

- We introduced the SKIN bundle (a set of practices aimed at reducing the number of pressure ulcers) across our ward areas. The number of patients suffering from a grade 3 or 4 pressure ulcer (the most severe) has gone down from 19 in 2010/2011 to 12 in 2011/2012.

- We have introduced 'intentional rounding' (this is a process where nursing staff carry out regular checks on patients, at set intervals, typically hourly, to check they are comfortable, pain free, provide a drink or help to the toilet) onto our orthopaedic wards. This process is aimed at reducing falls in hospital. It is too early to tell what the results are of this work are, but initial findings are that on the pilot wards falls are reducing and we shall be spreading this initiative across all wards in 2012/2013.

- Recognition of the deteriorating patient has been a focus over the last two years. This year we launched a revised observation chart for all patients and simplified the escalation process (calling for senior help early). After its introduction our audit data showed a much stronger compliance with observations (pulse, blood pressure and breathing rate) and escalation of those patients who were deteriorating. This sits alongside increasing calls from the wards to the critical care outreach team and a corresponding reduction in cardiac arrest calls this year. This is a very positive picture and as a result our team have given talks in the region on how this has been achieved.

The bar chart below shows an increase in the number of patients recognised as deteriorating, calls to the critical care outreach team and a reduction in cardiac arrests from January 2010 to December 2011. EWS = Early Warning Scoring System which helps staff recognise a deteriorating patient.



Reducing Harm from High Risk Medicines:

- We have continued to reduce the risks associated with under or over prescribing Warfarin (blood thinning medicine) through these patients' treatment being overseen by the anticoagulation nurses who have introduced more frequent monitoring of blood levels for inpatients. This team have also overseen the production of an improved anticoagulant prescription chart which provides better information for staff.

- We have continued to reduce the risks of insulin through the Think Glucose Campaign. Our Diabetes team have produced an educational DVD for all wards. They have updated the guidance for patients with diabetes undergoing surgery and have produced a patient information leaflet on this which is in line with national guidance. They have also produced an inpatient Diabetes handbook. Our percentage of patients with diabetes who are treated as day cases is better than the national average.

- We have introduced medicines reconciliation (this is the checking of medications that patents are taking with the GP) when patients are admitted through our Medical Assessment Unit. The ward pharmacist can now view the GP computer system to ensure that we continue with the appropriate medicines in hospital and this is particularly important for patients who are on lots of medications or who can't tell us themselves what they have been taking.

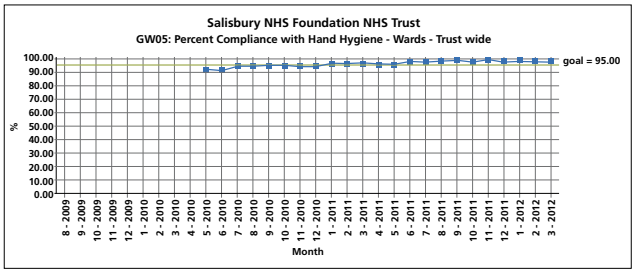
Reducing Harm in Perioperative Care (Theatres)

- In the operating theatre we continued to ensure that the World Health Organisation Safe Surgery checklist was in place for all operations. This is now built into our computerised theatre system and so is mandatory for every case.

Infection Prevention and Control

In our last Quality Account we said that we would work with staff, patients and visitors to maintain high standards of infection prevention and control. During the year we have achieved the following.

- Our focus on good infection prevention and control continued with the 'Clean Your Hands Campaign'. As a minimum, ward based hand washing audits took place every month. Our results show us that over 90% of staff who should wash their hands, do so. The table below shows sustained improvement in this practice.



- Senior nurses and cleaners continued to meet three times a week to monitor infection prevention and control across the hospital.

- We continued to monitor cleaning standards through our cleaning audit programme. We use a nationally recognised accredited system to measure the cleanliness of the hospital. We put more cleaning hours into high risk areas for example the Intensive Care Unit. We achieved all the national standards set for cleanliness.

- We continued to monitor antibiotic prescribing practices across all specialities in order to ensure appropriate practice.

- Senior nurses, ward leaders, infection control nurses, and staff in housekeeping and estates continued to monitor all aspects of infection control and cleanliness through the Matrons Monitoring Group.

- We monitored surgical infection rates in hip and knee replacement patients and there were no wound infections in these cases.

- We completed the second phase of the bedpan washer replacement programme and the upgrade of sluice rooms.

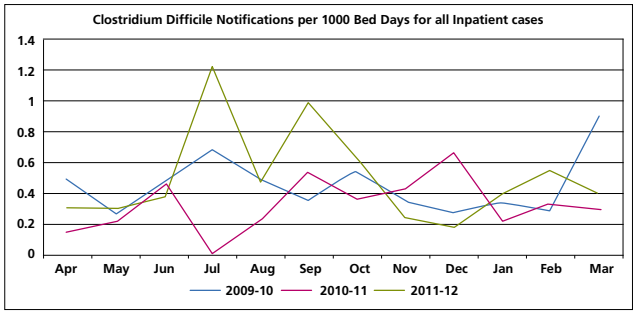
- We continued to monitor the cleanliness of equipment using the ATP monitoring system (this system detects microorganisms on surfaces).

- Our Governors continued to take part in monitoring the cleanliness of clinical areas through PEAT inspections.

- In 2011/2012 there were 111 cases of Clostridium Difficile reported in our laboratory. Of these 44 were inpatient cases classed as hospital apportioned. In July 2011 we carried out a review following a rise in the number of cases and found no link between them. However we took this issue very seriously and did identify some learning and do have recommendations in place which have now been completed, such as a review of the

ward cleaning task lists which set out clearly what the cleaning responsibilities for ward staff and cleaners are on a daily basis, regular walk rounds of senior nurses and cleaning supervisors to sign off that cleaning has been carried out to an acceptable level. We also carried out a deep cleaning programme throughout the hospital (every ward) which will now happen every year. Since the increased incidence in the summer of 2011 there has been a reduction in the number of hospital apportioned cases which can be seen in the graph below.

The line graph below shows Clostridium Difficile rates per 1000 bed days at this hospital between 2009 to 2012.



- We had 4 cases of hospital apportioned MRSA blood stream infections during 2011/2012. Each case was thoroughly reviewed and none of these were related to each other.

- The Trust now ensures that all emergency patients are screened for MRSA on admission.

The table below (at foot) shows the number of hospital apportioned MRSA blood stream notifications in this hospital between 2008 to 2012.

Nutrition:

In our last Quality Account we said that we would continue to focus on the importance of nutrition and the following has been achieved:

- We continue to hold Baby friendly status which recognises the importance of early contact between mother and child and breastfeeding.

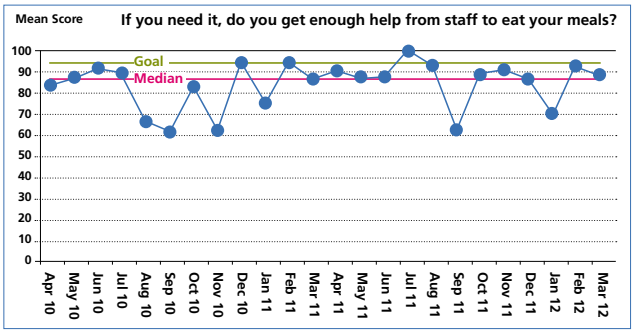
- The Food and Nutrition group has been particularly active this year. New specialist scales were bought for all patient areas.

- A nutritional awareness week was held in September 2011 which included daily training sessions for staff and displays around the hospital.

- Senior nursing staff and Governors continued to observe mealtimes in different wards every 2 weeks. The observers looked at the environment for eating in, the food and food service, and the help that patients were receiving where it was needed.

- In our real time feedback patients have told us that they get the support that they need but this needs to be done consistently.

The table below shows patient real time feedback from April 2010 to March 2012 on help from staff at meal times.



What will we do in 2012/2013?

We will continue to work with staff, patients and visitors to maintain high standards of infection prevention and control in the following ways:

- Complete the final phase of the bedpan washer replacement programme and sluice room upgrade on every ward as well as reviewing macerators which are bedpan disposal units. In addition we will review outpatient areas.

- Continue to review Trust infection prevention and control policies to ensure the Trust remains compliant with current best practice.

- Continue to reduce our infection rates, particularly related to lines, through the implementation of care bundles.

MRSA	2008/09	2009/10	2010/11	2011/12
Number of hospital acquired MRSA blood stream notifications	2	4	0	4

- Continue to monitor the cleanliness of equipment and the environment, using the hygiene monitoring system (this monitors the effectiveness of our cleaning regimes and will detect it there are any microorganisms). This will also be used to monitor good hand hygiene practice.

- We will continue to monitor practice through the audit programme and report these to the Infection Control update meetings and matrons monitoring group meetings.

- We will continue to review up to date innovations and technologies to ensure best practice in infection prevention and control.

We will work with our staff and patients to continue our safety work:

- We will introduce the safety thermometer. This is a tool that has been developed for use across the country and will measure the following harmful events on one day each month across the hospital – pressure ulcers, falls, urinary tract infections in patients with a urinary catheter, and VTE (blood clots). This will allow us to monitor our own work in reducing patient harm and also eventually allow us to compare ourselves to other hospitals.

- We will continue to improve the nutrition of our patients through the work described in Priority 2.

How will we report progress throughout the year?

- Infection control, pressure ulcers, falls resulting in harm are all reported to the Trust Board, Clinical Management Board and Operational Management Board monthly and the Clinical Governance Committee every 2 months.

- Safety Steering group meets monthly and reports to the Clinical Governance Committee every 6 months via the Safety Programme Report.

Statements of assurance from the Board

Review of Services

During 2011/2012 Salisbury NHS Foundation Trust provided and/or subcontracted 44 NHS services. Salisbury NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services. The income generated by the NHS Services reviewed in 2011/2012 represents 100% of the total income generated from the provision of NHS services by Salisbury NHS Foundation Trust for 2011/2012.

The Trust has published a Quality Strategy 2012 – 2015 in which it sets out a quality governance framework for the review of individual services. This includes the completion of the Salisbury Organisational Trigger Tool which alerts us to risks relating to quality of care and to put plans in place for improvement. It also includes a review of quality information to provide assurance of effectiveness, safety and a good patient experience in each individual service. Information reviewed includes a Directorate quality indicator and measures report or dashboard, clinical audit results, patient survey feedback, real time patient feedback, comments, complaints and compliments and a risk report card highlighting adverse events. This information is discussed quarterly at Directorate performance meetings and the Department Executive Safety and Quality walk rounds. The Directorate Management Team present their quality and safety outcomes and improvement work to the Clinical Governance Committee every year as part of the assurance process.

There is a clear quality reporting structure in the Trust where scheduled reports are presented and discussed at the Clinical Management Board or Clinical Governance Committee. Many of the reports are also reported to our commissioners as part of our requirement to provide assurance on contract and quality performance compliance.

Each year the Trust has a number of external agency and peer review inspections. The reports, recommendations and action plans are discussed at one of the assuring committees. For example the Trust had an unannounced inspection by the Care Quality Commission in May 2011 who identified five minor concerns. Their report, recommendations and our action plan were discussed at the Trust Board in August 2011. However, three recent Health and Safety Executive improvement notices have been served on the Trust in respect of violence and aggression towards staff and dermatitis prevention. Robust action plans are in place to address these issues.

Areas where problems or concerns have been identified have action plans for improvement and these are monitored through the Trust 3:3 performance management meetings. Any recurrent themes can be included as key objectives for improvement in the Trust service plan or the following year's Quality Account priority areas.

Participation in Clinical Audits

During 2011/2012, 51 national clinical audits (of which 19 are ongoing data sets) and 5 national confidential enquiries covered NHS services provided by Salisbury NHS Foundation Trust.

During that period, Salisbury NHS Foundation Trust participated in 42 (82%) of national clinical audits and 5 (100%) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Salisbury NHS Foundation Trust was eligible to participate in during 2011/2012 are listed in the table below.

The national clinical audits and national confidential enquiries that Salisbury NHS Foundation Trust participated in, and for which data collection was completed during 2011/2012 are listed in the table below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audits	Eligible	Participation	% of cases submitted to each audit
Peri and Neo-natal			
Perinatal Mortality (MBRRACE-UK)	Yes	Yes	100%
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
Children			
Paediatric Pneumonia (BTS)	Yes	No	N/A
Paediatric Asthma (BTS)	Yes	No	N/A
Pain Management (CEM)	Yes	Yes	100%
Childhood Epilepsy (RCPH)	Yes	Yes	100%
Paediatric Intensive Care (PICANet)	No	N/A	N/A
Paediatric Cardiac Surgery (NICOR)	No	N/A	N/A
Diabetes (RCPH)	Yes	Yes	100%
Acute Care			
Emergency Use of Oxygen (BTS)	Yes	Yes	100%
Adult Community Acquired Pneumonia (BTS)	Yes	Yes	100%
Non Invasive Ventilation – Adults (BTS)	Yes	Yes	100%
Pleural Procedures (BTS)	Yes	No	N/A
Cardiac Arrest (National Cardiac Arrest Audit)	Yes	No	Ongoing local audit as part of safety work stream
Severe Sepsis and Septic Shock (CEM)	Yes	Yes	100%
Adult Critical Care (ICNARC)	Yes	Yes	100%
Seizure management	Yes	Yes	100%
Long Term Conditions			
Diabetes – Adults	Yes	Yes	100%
Heavy Menstrual Bleeding (RCOG)	Yes	Yes	100%
Chronic Pain	Yes	Yes	100%
Ulcerative Colitis and Crohn's Disease (UK IBD Audit)	Yes	Yes	100%
Parkinson's Disease	Yes	Yes	100%
Adult Asthma (BTS)	Yes	No	N/A
Bronchiectasis (BTS)	Yes	No	N/A
Elective Procedures			
Hip, knee and Ankle Replacements (National Joint Registry)	Yes	Yes	100%

Elective Surgery (PROMs)	Yes	Yes	Variable across 4 procedures
Intra-thoracic Transplantation (NHSBT UK)	Yes	No	N/A
Liver Transplantation (NHSBT UK)	Yes	No	N/A
Coronary Angioplasty (NICOR Adult Cardiac Interventions Audit)	Yes	No	N/A
Peripheral Angioplasty (VSGBI Vascular Surgery Database)	Yes	Yes	100%
Carotid interventions	Yes	Yes	100%
CABG and Valvular Surgery (Adult Cardiac Surgery Audit)	No	N/A	N/A
Cardiovascular Disease			
Acute Myocardial Infarction and Other ACS (MINAP)	Yes	Yes	100%
Heart Failure	Yes	Yes	100%
Acute Stroke (SINAP)	Yes	Yes	100%
Cardiac Arrhythmia (Cardiac Rhythm management Audit)	Yes	Yes	100%
Renal Disease			
Renal Replacement Therapy (Renal Registry)	No	N/A	N/A
Renal Transplantation (NHSBT UK)	No	N/A	N/A
Cancer			
Lung Cancer (NLCA)	Yes	Yes	100%
Bowel Cancer (NBCAP)	Yes	Yes	100%
Head and neck Cancer (DAHNO)	Yes	Yes	100%
Oesophago-Gastric Cancer	Yes	Yes	100%
Trauma			
Hip Fracture	Yes	Yes	100%
Severe Trauma (TARN)	Yes	Yes	100%
Psychological Conditions			
Prescribing in Mental Health Services (POMH)	No	N/A	-
Schizophrenia	No	N/A	-
Blood Transfusion			
Bedside Transfusion	Yes	Yes	100%
Medical Use of Blood	Yes	Yes	100%
Health promotion			
Risk Factors (National Health promotion in Hospitals Audit)	Yes	Yes	100%
End of Life			
Care of the Dying in Hospital (NCDAH)	Yes	Yes	100%
Additional national audits the Trust took part in			
Consultant sign-off 2011 (CEM)	Yes	Yes	100%
Stroke: Hospital Services	Yes	Yes	100%
Use of platelets (NBS)	Yes	Yes	100%
National Audit of Services for People with Multiple Sclerosis - Service providers 2011	Yes	Yes	100%
National Audit Cardiac Rehabilitation	Yes	Yes	100%
Audit of complex urological operations	Yes	Yes	100%
National vascular database	Yes	Yes	100%
NHS Blood & Transplant: potential donor audit	Yes	Yes	100%

The reports of 12 (86%) out of 14 published national clinical audits were reviewed by Salisbury NHS Foundation Trust in 2011/2012. Of these 12 (86%) were formally reported to the Clinical Management Board by the clinical lead responsible for implementing the changes in practice and Salisbury NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

The table below shows the national clinical audit reports reviewed during 2011 and examples of resulting action being taken by Salisbury NHS Foundation Trust.

Audit report	**Reviewed by whom**	**Action taken or required to improve**
NCEPOD – Trauma: Who Cares?	Trauma Care Delivery Group and Clinical Management Board in September 11	Audit confirmed ambulance staff are able to talk to senior staff in the Emergency Department about a severely injured patient.
NCEPOD – For Better for Worse? A review of the care of patients who died within 30 days of receiving systemic anti-cancer therapy	Clinical Management Board	All patients who die within 30 days of receiving chemotherapy are reviewed at a mortality meeting. E-prescribing (electronic prescribing to standardise treatment) is in the process of implementation. Internal validation of chemotherapy services took place in November 2011 with 85.4% compliance. A targeted peer review visit is due to take place Feb 2013.
National Falls and Bone Health Audit	Falls working Group and Clinical Management Board in November 11	Continue with the roll out of 'Intentional Rounding' to all wards Raise family awareness of a patient's risk of falls in hospital and what they can do to help prevent falls.
National Diabetes Audit	Diabetes team meeting Clinical Management Board in July 11	Improve administration of insulin by enabling inpatients to manage their own injections. We need to take greater account of the 'expert patient' in the management of their own diabetes. Continue the staff education programme.

Care of the Dying in Hospital (NCDAH)	End of Life Care Strategy Steering Group Clinical Management Board in March 11 Clinical Governance Committee September 11	Develop staff communication skills & continue end of life care education. Improve documentation in the 'care of the dying pathway'. Continue with rapid discharge for patients who wish to die at home.
Non-invasive ventilation (NIV)	Critical Care Delivery Group in September 2011 Clinical Management Board in November 2011	Ensure that patients at risk of carbon dioxide retention carry an oxygen card. Continue the junior doctor NIV training programme.

The Trust expects to formally review all national audits at the Clinical Management Board within 2 months of publication. This gives the clinical teams time to discuss the findings and to develop an action plan which is presented to the CMB for approval and support.

Action plans have been developed for all national audits and confidential enquiries published during the year. Monitoring of these actions are through the Trust 3:3 performance management structure or through designated working groups. For example the National End of Life Care audit action plan is monitored through the End of Life Strategy Steering Group and reported to the Clinical Management Board.

The reports of 107 (48%) of local clinical audits were reviewed by the Trust in 2011/2012 and Salisbury NHS Foundation Trust intends to take or has already taken the following actions to improve the quality of healthcare arising from the audits:

- A report of all clinical audit results that indicate a risk to patients or the organisation is reported to the Clinical Risk Group – an example of this work is the Consent Audit. This showed we need to make improvements in documenting patients have been given an information leaflet about a procedure.

- All infection control audit reports were reviewed by the infection control working group. Examples of this work are regular monthly audits of staff to ensure those who wear a scrub style uniform do not wear a sleeve or garment below the elbow so they can wash their hands properly. We achieved 98.7% compliance. Mattress audits are also undertaken regularly to ensure the integrity of the mattress. Damaged mattresses are replaced immediately.

- Ward based audits based on 'essence of care' such as nutrition, communication, privacy and dignity were undertaken. A number of changes have been introduced such as ' intentional rounding' for patients at high risk of falls and protected mealtimes to ensure patients receive help with eating and drinking at mealtimes.

- 15 audits were undertaken by the maternity service in quarter three to support the NHSLA (NHS Litigation Authority) standards – NHSLA level 2 was maintained. Improvements areas have included that all women are reviewed by a senior doctor before starting a hormone drip to augment labour.

Salisbury NHS Foundation Trust participates in a number of audits that are not on the National Clinical Audit Advisory Group list and these have been included in the table above. This activity is in line with the Trust's annual clinical audit programme which aims to ensure that clinicians are actively engaged in all relevant national audits and confidential enquiries as well as undertaking baseline assessments against all NICE guidelines and quality standards. This enables the Trust to benchmark our performance against others nationally and to determine the focus of improvement programmes. The annual programme also includes a number of audits agreed as part of the contract with our commissioners.

Research

The number of patients receiving NHS services provided by Salisbury NHS Foundation Trust in 2011/2012 that were recruited during that period to participate in research approved by the National Research Ethics Committee was 614. This compares to 407 in 2010/2011*.

The level of participation in clinical research demonstrates Salisbury NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

*End of year recruitment figures will not be finalised until later in the year. Please note that last year's account stated 339 patients recruited to trials but this increased to 407 once the full year figures were validated later in the year.

Goals agreed with Commissioners

A proportion of Salisbury NHS Foundation Trust's income in 2011/2012 was conditional upon achieving quality improvement and innovation goals agreed between Salisbury NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality payment framework. Further details of the agreed goals for 2011/2012 are set out in the table below. The planned income through this route for 2011/2012 was £2,200,000 (In 2010/11 it was £1,902,000). The amount the Trust received in 2011/2012 was £2,060,000 (in 2010/2011 it was £325,000).

CQUIN contracts were signed with our commissioners during 2011/2012 as part of their overall contract. The Trust achieved some of the quality improvements as set out in the table below. In the CQUINs not achieved, these were particularly challenging needing a whole health economy approach to ensure patients are discharged in a timely manner and supported at home. Our quality priorities in 2012/2013 reflect the need to continue to work with our partners to improve these aspects of care. The Trust is currently having positive discussions to agree a CQUIN for 2012/2013. Further details of the agreed goals for 2011/2012 and for the following 12 month period are available from the Finance Department, Salisbury NHS Foundation Trust, Salisbury District Hospital, Wiltshire, SP2 8BJ.

CQUIN indicators (Wiltshire and Hampshire)

Goals	CQUIN indicators	Domain	Target 11/12	Performance in 11/12
1	Venous-thromboembolism (VTE) risk assessment & prophylaxis – reduce avoidable deaths, disability and chronic ill health from VTE	Safety	90%	92.3% - assessment 96.6% - prophylaxis
2	Improve responsiveness to personal needs of patients	Patient experience	68.8	69.2
3	Reduction in the number of hospital deaths	Safety Outcomes Experience	10% reduction on 273 deaths (Jan – Dec 10)	273 Jan – Dec 11
4	Reduction in average length of stay in elective and non elective admissions of patients staying 2 days or over	Outcomes Experience	10% reduction in elective from 5.8 days and non elective from 11.9 days	Elective 5.9 days Non elective 10.9 days
5	Reduction in short stay emergency admissions	Outcomes Experience	20% reduction from 7490 patients in 10/11	7225 patients

Goals	CQUIN indicators	Domain	Target 11/12	Performance in 11/12
6	Improve discharges 7 days a week	Safety Experience	4% increase in weekend discharge rate from 14.6% in 10/11	Weekend discharge rate 14.8%
7	Improved discharge summary information	Safety Experience	90% of discharge summaries contain personalised information	Ongoing
8	Improved stroke care so that 100% of patients receive a therapy assessment within 48 hrs with therapy delivered 7 days a week, are referred to community services within 3 days of admission and length of stay is reduced	Effectiveness	100% therapy assessment within 48 hrs & therapy delivered 7 days a week. 98% patients referred to community services within 3 days of admission 20% reduction in length of stay from an average of 18.8 days.	98% assessed within 48 hrs. 83% received therapy over 7 days. (7 day service started on 1/3/12) 71% 16.9 days
	Hampshire only			
9	To reduce the number of patients with urinary catheters put in inappropriately	Safety	Reduction on Q3 baseline Q3 – 12% of catheters were inappropriate	Q4 – 21% of catheters were inappropriate
10	To improve the health of the population by ensuring that all patients are screened for alcohol risk using a screening tool, receive brief advice and referral to their own GP attending the Emergency Department	Effectiveness	Increase by quarter Q1 – set up Q2 20% Q3 40% Q4 80%	Commenced 1/4/12

Care Quality Commission (CQC Registration}

Salisbury NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions.

The Care Quality Commission has not taken enforcement action against Salisbury NHS Foundation Trust during 2011/2012.

Salisbury NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2011/2012.

Data quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. Improving data quality, which includes the quality of ethnicity and other equality data, will thus improve patient care and improve value for money.

Salisbury NHS Foundation Trust will be taking the following actions to improve data quality:

- There will be a particular focus to the process of data collection to encourage a 'getting it right, first time' culture.
- Continue with an audit programme and peer review of data and change practices accordingly.
- Users will continue to be automatically notified when a specific requirement of data collection is not met.
- Continue to design and adjust data collection systems to prevent collection of poor quality data.
- Continue the Data quality Improvement Group where issues regarding data collection and reporting are discussed and improved upon.

To ensure our data quality is able to support the assurance of overall care quality the Trust manages a Data Quality Service. The Data Quality Service aim to ensure staff record clinical information accurately on every occasion. The service achieves this by supporting good practice in the process of data collection, this ensures the person coding the episode of care has the right information about the care given and the appropriate training to ensure accurate data capture. The Data Quality Service staff spend time working with doctors and administrative staff to demonstrate best practice as well as errors made. Errors are detected through the use of automatic electronic data quality reports and rectified by the person who recorded the data incorrectly. Data quality reports include volumes and types of errors and are reported to the Data Quality Improvement Group, Directorate 3:3 meetings and the Information Governance Steering Group. The Data Quality Service continually monitors and audits data quality locally and participates in an external audit which enables the Trust to benchmark its performance against other Trusts

The use of these techniques gives the Trust assurance that the information regarding quality of care given is an accurate representation of performance.

Salisbury NHS Foundation Trust submitted records during 2011/2012 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The table below shows the percentage of records in the published data which includes the patient's valid NHS number and General Practitioner Registration code. These are important because the NHS number is a key identifier for patient records and an accurate record of the General Practitioner Registration code is essential to enable the transfer of clinical information about the patient.

Data item	Salisbury District Hospital 10/11	National benchmark 10/11	Salisbury District Hospital 11/12 As at M11	National benchmark 11/12 As at M11
% for admitted patient care with a valid NHS number	98.8%	98.4%	99.1%	98.8%
% for outpatient care with a valid NHS number	99.1%	98.8%	99.3%	99.0%
% for Emergency Department care with a valid NHS number	96.3%	91.6%	97.0%	93.3%
% for admitted patient care with a valid General Practitioner Registration code	100%	99.8%	100%	99.8%
% for outpatient care with a valid General Practitioner Registration code	100%	99.8%	100%	99.7%

% for Emergency Department care with a valid General Practitioner Registration code	100%	99.7%	99.9%	99.4%

Information Governance Toolkit Attainment levels

Salisbury NHS Foundation Trust's Information Governance Assessment report overall score for 2011/2012 is 85% and was graded as satisfactory (green). The assessment provides an overall measure of the quality of data systems, standards and processes within the organisation. The Trust showed an improvement in comparison to 79% in 2010/2011. The Trust achieved the necessary standard for all areas assessed.

Clinical Coding Error Rate

Clinical coding translates the medical terminology written in a patient's health care record to describe a patient's diagnosis and treatment into a standard, recognised code. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records and underpins payments and financial flows within the NHS

Salisbury NHS Foundation Trust was subject to a Payment by Results clinical coding audit during 2011/2012 by the Audit Commission and the error rate reported in the latest published audit for that period for diagnoses and treatment coding were:

Primary diagnosis incorrect 6.5%
Secondary diagnoses incorrect 3.0%
Primary procedures incorrect 3.6%
Secondary procedures incorrect 6.9%

The results should not be extrapolated further than the actual sample audited.

The following areas were audited in 2011/2012:

- Paediatrics – The Audit Commission commented that the diagnosis error rate in Paediatrics had significantly improved since their audit in 2007/2008. This is due to increase in the coding skills gained through experience and training.
- A random selection of health care records from all specialities

The following improvement actions are planned for 2012/2013:

- The quality of the filing within the case notes folder.
- The recording process on the Patient Administration System to allow an accurate reflection of shared care activity.
- Continue with awareness training for doctors and nurses on the impact of inconsistent terms.

PART 3

Review of Quality Performance

This section gives information relating to the quality of services that Salisbury NHS Foundation Trust provides through a range of selected measures of patient safety, effectiveness and experience. These areas have been chosen to cover the priority areas highlighted for improvement in this Quality Account, as well as areas which our patients have told us are important to them, such as cleanliness and infection prevention and control. Our commissioners measure a number of these measures, the Strategic Health Authority drive the safety programme and our CQUIN contract supports improvement measures.

These indicators are included in monthly quality indicator and measures report that is reported to the Board and Clinical Governance Committee.

Patient Safety Indicators							
	2008/09	**2009/10**	**2010/11**	**2011/12**	**National average**	**What does this mean?**	**Source of measure**
1.Mortality rate (HSMR) SHMI (new measure 2011/12)	96 n/a	100* n/a	95* n/a	94 (April 11 – January 12) 96	100 100	Lower than 100 is good	Based on the national definition of Dr Foster's HSMR. Based on the national definition in the NHS Information Centre
2. MRSA notifications**	2 (5)	4 (5)	0 (5)	4 (5)	Not available	0 is excellent	National definition
3. C. difficile infection per 1,000 bed days	0.3	0.45	0.32	0.51	Not available	Lower than national average	National definition
4. Global Trigger adverse events rate	44	42	31***	41 up to Feb 12	40	Lower score the better	Definition based on Patient Safety First Campaign
5. 'Never events' that occurred in the Trust.****	0	0	2 (These were associated with surgery & rectified with no long term harm)	1 (This was associated with surgery with no patient harm)	Not available	0 is good	Definition from National Patient Safety Agency
6. Patient falls in hospital resulting in a fracture or major harm	Not measured	24	21	32	Not available	Low number is good	Definition from National Patient Safety Agency
Clinical Effectiveness indicators							
7. Patients having surgery within 36 hours of admission with a fractured hip	60%	75%	74%*****	87%	90%	Higher number is good	Based on national definition with data taken from hospital system and national database.

8. % of patients who had a risk assessment for VTE (venous thromboembolism)	57%	72%	91%	92%	90%	Higher number better	Based on national definition with data taken from hospital system and national database.
9. % patients who had a CT scan within 24 hrs of admission with a stroke	56%	89%	90%	92%	Not available	Higher number better	Based on national definition with data taken from hospital system and national database.
10. Compliance with NICE Technology Appraisal Guidance published in year	83%	92%	80%	70%	Not measured	Higher number better	Local indicator
Patient experience indicators							
11. Number of patients reported with grade 3 & 4 pressure ulcers	45	58	19	12	Not available	Lower number is better	National definition with data taken from hospital reporting systems
12. % of patients who felt they were treated with dignity and respect	81%	80%	81%	79% Yes always 19% Yes sometimes	Not available	Higher number is better	Data taken from national inpatient survey
13. % of patients stating the quality of care was very good or better	80%	75%	81%	78%	Not available	Higher number is better	Data taken from national inpatient survey
14. % of patients in mixed sex accommodation	19%	14%	11%	11%	Not available	Lower number is better	Data taken from national inpatient survey
15. % of patients who stated they had enough help from staff to eat their meals	60%	55%	67%	63%	Not available	Higher number is better	Data taken from national inpatient survey

16. % of patients who thought the hospital was clean	61%	65%	66%	65%	Not available	Higher number is better	Data taken from national inpatient survey
17. % of patients who would recommend the hospital to a family or friend	82%	86%	88%	89%	Not available	Higher number is better	Data taken from Trust real time feedback system

* In previous annual reports the HSMR was reported as 101 in 2009/10 and 97 in 2010/11. However, in 2011/12 HSMR was rebased and our figures were rebased to 100 in 2009/10 and 95 in 2010/11.
** In previous annual reports the Trust quoted Trust and non-Trust apportioned MRSA notifications as a total figure. This will have included community hospital and GP patients. The total figure is quoted in brackets in the table.
*** The Global Trigger/adverse events rate was published as 33 up to 31 Jan 2011 in the 2010/11 quality report. The total figure for the full year in 2010/11 was 31.
**** Never events are adverse events that should never happen to a patient in hospital. An example is an operation that takes place on the wrong part of the body. The never events list increased from 8 to 25 on 1 April 2011.
***** In 2010/2011 Quality Account the Trust quoted 80% of patients having surgery within 36 hours of admission with a fracture neck of femur (hip). The National Hip Fracture report 2011 indicated the Trust achieved this with 74% of patients based on full year figures.

National Targets and Regulatory Requirements

	2008/09	**2009/10**	**2010/11**	**2011/12**	**Target for 2012/13**
C Difficile year on year reduction (from 10/11 positive samples taken within 72 hrs of admission are reported as non Trust apportioned)*	73	79	52 (31 Trust apportioned, 21 non Trust apportioned)	111 (44 Trust apportioned 67 non Trust apportioned)	25
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half of the 03/04	2 (5)	4 (5)	0 (5)	4 (5)	1
Maximum waiting time of 2 weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	100%	94.5%	94.7%	93.9%	93%
2 week wait for symptomatic breast patients (cancer not initially suspected)	31.5%	89.2%	96.6%	97.3%	93%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	99.3%	96%	98.5%	97.9%	96%
Maximum waiting time of 31 days for subsequent treatments of all cancers – anti cancer drug treatments.	n/a	99.4%	100%	100%	98%

Maximum waiting time of 31 days for subsequent treatments of all cancers - surgery	n/a	98.1%	98.5%	99.3%	94%
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	96.1%	85%	92.7%	93.2%	85%
62 day wait for first treatments from consultant screening service referral: all cancers	n/a	93.8%	100%	97.2%	90%
For admitted patients, maximum time of 18 weeks from point of referral to treatment	90.8%	90%	94.9%	93.5%	90%
Referral to treatment times admitted (95th percentile) 23 weeks	n/a	n/a	n/a	18.4 weeks	23 weeks
For non-admitted patients, maximum time of 18 weeks from point of referral to treatment	95.1%	95%	98.6%	98.1%	95%
Referral to treatment times non-admitted (95th percentile) 18.3 weeks	n/a	n/a	n/a	17.0 weeks	18.3 weeks
Maximum waiting times of 4 hours in the Emergency Department from arrival to admission, transfer or discharge	98.2%	98.3%	97.8%	97.86%	95%
Quarter 1 2011-12 Total time in A&E (95th percentile) less than 4 hours report	n/a	n/a	n/a	3 hours 38 minutes	< 4 hours
A&E from Q2					
Total time in A&E (95th percentile) less than 4 hours	n/a	n/a	n/a	3 hours 57 minutes	< 4 hours
Time to initial assessment (95th percentile) less than 15 minutes	n/a	n/a	n/a	0	15 minutes
Time to treatment decision (median) less than 60 minutes	n/a	n/a	n/a	66 minutes	< 60 minutes

Unplanned reattendance rate less than 5%	n/a	n/a	n/a	2.0%	5%
Left without being seen less than 5%	n/a	n/a	n/a	2.44%	< 5%
Self certification against compliance with requirements regarding access to health care for people with learning disabilities	Not measured	Not measured	Compliant	Compliant	Maintain compliance

* In 2008/2009 and 2009/2010 the Trust quoted total number of positive samples recorded at the hospital based on national definitions in place at the time. This included community hospital, GP patients and Trust inpatients. This is reflected in the figures above from 2008 to 2010. From 2010/2011 the definition changed and this reflects the number of positive Trust in-patient cases split between Trust apportioned (over 72 hrs after admission) and non-Trust apportioned (less than 72 hrs of admission).

Statements from NHS Wiltshire (Lead Commissioning PCT)

NHS Wiltshire, as lead commissioner for Salisbury Foundation Trust, is pleased to assure the Trust's third annual Quality Account. The document is clearly presented in the format required by the Department of Health Toolkit and the information it contains accurately represents the Trust's quality profile.

Our view is that Salisbury Foundation NHS Trust provides, overall high quality care for patients, with strong leadership and a positive culture within the Trust. Salisbury Foundation Trust achieves good results in National surveys of patient experience; its hospital standard mortality ratio is below the national average. The Trust is constantly striving to improve patient experience and care. During 2011/2012, Salisbury Foundation Trust made positive progress in a number of areas including: Dementia Services and reduction of incidence of grade 3 and 4 pressure ulcers.

The Quality Account acknowledges the level of the challenge posed in some 2011/12 priorities, particularly in relation to Clostridium difficile. We believe the specific priorities for 2012/13 which the trust has highlighted in the report are appropriate areas to target for continued improvement, in line with our commissioning priorities and linked to quality innovation for 2012/13. We strongly support Salisbury Foundation Trust's decision to continue to improve the end of life care for people in Wiltshire who use the services as their first priority for 2012/13. We endorse their pledge to keep patients safe during their stay in hospital, ensure privacy and dignity is maintained and that services users should receive timely and effective hospital treatment.

Demonstrating service user involvement in the development of Quality Account is an opportunity for Trusts to evidence their commitment to listening to their service users and their carers. We therefore welcome the inclusion of success measures within the Quality Account, providing a gauge upon which service users, carers and commissioners can appraise the Trust's achievements in the coming year.

NHS Wiltshire looks forward to continuing to work with Salisbury Foundation Trust as they fulfil their commitment to continuously improve the quality of care for our local health service users, their families and carers.

NHS Wiltshire is fully committed to continuing its close co-operation with the Trust over the coming year on these important issues.

Statement from Wiltshire Council Health and Adult Social Care Select Scrutiny Committee

The Committee agreed to undertake a small group exercise to consider the draft Quality Account provided as it was required to collate comments from other local authority OSCS as the 'appropriate authority' for the Salisbury Foundation Trust.

Although the Committee resolved to disengage from the Quality Accounts process at the end of 2011, it recognised that the process had encouraged better communication with the Trust and had allowed members a better understanding of the ambitions, priorities and challenges faced by the Trust.

In agreeing to undertake its coordination role only this year, the group did consider the QA provided by SFT as the 'appropriate authority'. Comments included:

- An acknowledgement of the improvements in shared wards from the previous year.
- That it recognised the positive comments on the quality of food provided but noted help from staff at meal times was generally below the Trust's own goal and that further improvements could be made in this area.

Although the group agreed with the Trust's priorities for 2012/13 as set out in the Quality Account it felt unable to respond with confidence to the content due in part to the limited contact with the Trust during the year. The group felt that the inclusion of national indicators and comparison data within the QA could have allowed the group to better evaluate the QA.

Hampshire County Council

The Hampshire HOSC does not contribute to the Quality Accounts of any of the providers it works with. It is satisfied that direct methods of raising concerns and discussing issues with providers.

Dorset County Council

Dorset Health Scrutiny Committee did not comment on the Quality Account for this year.

Statement from Wiltshire Involvement Network (LINKS)

The Wiltshire Involvement Network has reviewed the Quality Account 2011-2012 produced by Salisbury NHS Foundation Trust and provided the following response.

Priority 1
We are pleased that the Trust will continue to improve the quality of end of life care. We note there was comment regarding getting care set up at home for someone who wanted to return home to die. We hope the Trust will always work closely with Social Services with regards to issues involving those who wish to return home to die.

Priority 2
We are pleased that the number of staff who completed the Mental Capacity Act training has increased and also that a Mental Health specialist nurse was appointed in 2011. We are also pleased to see that the Trust received a positive report from the South West Region on the care provided for dementia patients.

Priority 3
We again like last year have no objection to further reducing the length of stay by 10%, however we do note that some patients are readmitted because they do not have the necessary support and information about their condition when they get home. Discussion of care needs must always be a priority before discharge. No evening discharge should ever take place without discussion with the family or a care home beforehand. We welcome the Trust's aim to provide timely and effective hospital treatment. To some extent this will depend upon the Clinical Commissioning Group's referral system working effectively.

Priority 4
We recognise that the Trust intends to ensure that the care patients receive in hospital is very good or excellent. We do however note that there are some concerns with regards to doctors and nurses not always introducing themselves. Patients do not always know what is planned for their care and treatment. Call bells are not always answered promptly, and noise, especially at night, is disturbing sleep.
The fact that the Trust still cooks all its meals on site using locally grown produce is still looked on very favourably by patients and the public alike and we hope that this will continue.

Priority 5
We recognise that the Trust will continue to make sure patients are kept safe during their stay in hospital. We are pleased that on the whole infection rates remain low and we believe that this is probably down to the fact the cleaning and housekeeping is done by staff directly employed by the Hospital and not by contractors and we hope that this arrangement will continue.

We support the CQUIN Goal indicators. With regards to indicator 7, we note the work to improve personalised information is ongoing and welcome the introduction of the electronic discharge summary in 2012/13.

We feel that in general the Trust and staff are working well in the interests of patients bearing in mind financial constraints and the saving that are required to be made in all parts of the NHS.

Phil Matthews,
Chair of the Wiltshire Involvement Network

How to provide feedback

All feedback is welcomed and the Trust listens to these concerns and steps are taken to address individual issues at the time. Comments are also used to improve services and directly influence projects and initiatives being put in place by the Trust.

Statements of Directors Responsibilities in Respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, Directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/2012;
- The content of the quality report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2011 to May 2012;
- Papers relating to quality reported to the Board over the period April 2011 to May 2012;
- Feedback from the commissioners dated 10 May 2012.
- Feedback from the governors dated 4 May 2012.
- Feedback from LINks (Wiltshire Involvement Network) (WIN) dated 8 May 2012.
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, presented to the Trust Board dated: 4 April 2011, 6 June 2011, 3 October 2011, 6 February 2012 and 2 April 2012.
- The 2011 national inpatient survey dated January 2012.
- The 2011 national staff survey dated 20 March 2012.
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 23 April 2012.
- Care Quality Commission quality and risk profiles dated November 2011 and March 2012.
- The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the quality report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;

- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- The quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitornhsft.gov.uk/annualreportingmanual).

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Luke March
Chairman
25 May 2012

Caspar Ridley
Chief Executive
25 May 2012

Independent Auditor's Report to the Council of Governors of Salisbury NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Council of Governors of Salisbury NHS Foundation Trust to perform an independent assurance engagement in respect of Salisbury NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:
- Number of Clostridium difficile infections; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
I refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").
My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011-12; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

I read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for my report if I became aware of any material omissions.

I read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2011 to May 2012;
- Papers relating to quality reported to the Board over the period April 2011 to May 2012;
- Feedback from the Commissioners dated 10 May 2012.
- Feedback from Governors dated 4 May 2012.
- Feedback from LINKs (Wiltshire Involvement Network, WIN) dated 8 May 2012.
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 4 April 2011, 6 June 2011, 3 October 2011, 6 February 2012 and 2 April 2012.
- The 2011 national inpatient survey dated January 2012;
- The 2011 national staff survey dated 20 March 2012.
- Care Quality Commission quality and risk profiles dated November 2011 and March 2012.
- The Head of Internal Audit's annual opinion over the trust's control environment dated 23 April 2012.
- Any other information included in my review.

I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). My responsibilities do not extend to any other information.

I am in compliance with the applicable independence and competency requirements of the Association of Chartered Certified Accountants (ACCA) Code of Ethics and Conduct. My team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Salisbury NHS Foundation Trust as a body, to assist the Council of Governors in reporting Salisbury NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Council of Governors as a body and Salisbury NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). My limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents listed above under the respective responsibilities of the Directors and auditors.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of my assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Salisbury NHS Foundation Trust.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011-12; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

Simon Garlick
Officer of the Audit Commission
Audit Commission
Collins House
Bishopstoke Road
Eastleigh
Hampshire
SO50 6AD

Date: 29 May 2012

Trust Strategy on Sustainability

Governments, organisations and individuals have a responsibility to think carefully about the environment and the impact that their actions may have. This is reflected in national legislation and phased targets to reduce carbon emissions by 80% by 2050. The NHS Sustainable Development Unit (SDU) has also set initial targets for the NHS of a 10% reduction in carbon emissions by 2015. Salisbury NHS Foundation Trust takes sustainability and carbon emissions seriously and uses the NHS Carbon Reduction Strategy and the SDU's Good Corporate Citizen (GCC) Self Assessment Tool to assess the Trust's impact on the environment. This also provides a practical framework for its own Sustainability and Carbon Reduction Strategy.

This strategy covers travel and transport, procurement, facilities management, workforce issues, community engagement, facilities and new buildings, which includes objectives, actions and targets. This strategy can be found at www.salisbury.nhs.uk. Sustainable practices are also corporate responsibilities and the strategy has been implemented through the Environmental Executive Committee, which reports to the Operational Management Board. There is also a process to report to the Trust Board.

Summary Performance

Area		Non Financial data	Non Financial data		Financial data	Financial data
		2010/2011	2011/2012		2010/2011	2011/2012
Greenhouse Gas Emissions	Scope 1 (Direct) GHG Emissions	Gas: 6395 Tonnes CO_{2e} 34,527,107 kWhs Transport; 176 tonnes	Gas: 6122 Tonnes CO_{2e} 33,051,027 kWhs Transport; 184 tonnes		Gas; £867,018 Transport; £138,041	*Gas; £1,116,261 Transport; £137,701
	Scope 2 (Indirect) GHG Emissions	6220 tonnes CO_{2e} 11,410,365 kWhs	5665 tonnes CO_{2e} 10,392,068 kWhs		£1,039,324	£1,026,330
	Scope 3 ** Official Business Travel Emissions	179 tonnes CO_{2e}	186 tonnes CO_{2e}		£339,867	£329,167

Waste minimisation and management	Absolute values for total amount of waste produced by the Trust Methods of disposal	1,189 tonnes High Temperature. Non Burn Treatment. Landfill. Recovery /Recycling	1,184 tonnes High Temperature. Non Burn Treatment. Landfill. Recovery /Recycling	Expenditure on waste disposal	£260,166	£275,242
Finite Resources	Water & Sewerage	142,287 m3	151,407 m3	Water & Sewerage	£330,123	£370,608

Source: Final Estates Return Information Collection (ERIC) information for 2010/2011 and 2011/2012

*Includes £1,290 annual CRC subsistance fee and £151,393 CRC allowances

** Please note that Scope 3 reporting includes business mileage rates but not public transport travel

Future Priorities and Targets

In 2011 the Government implemented the Concerned about Carbon Reduction Commitment Scheme (CRC). This is the UK's mandatory climate change and energy saving scheme. The hospital is part of this and is required to report on the amount of CO2 that it produces. This figure will determine the ranking of the Trust in the national CRC performance league table. The Trust will monitor its position in the table as one of the key external indicators of environmental performance.

The Trust will continue to use the GCC together with CRC information as the basis for its own internal priority areas for the future. These are incorporated in the Trust's comprehensive action plan which can be found at: www.salisbury.nhs.uk. This will be monitored through the Environmental Executive Committee, together with a reporting process that includes the Operational Management and Trust Board. The priority areas and targets are summarised below:

Travel

Policies and performance: The Trust set itself an objective in 2011/12 to reduce the carbon that it is responsible for from the vehicle fleet it has. In line with this objective, six new vehicles have been leased for the courier fleet. These vehicles have Euro 5 engines which have the lowest emissions in their class. In addition, a vehicle review ensured that the correct sized vehicle appropriate for the workload were leased, which contributed to further savings.

Active Travel: The Trust had a vision to engage with staff and the local community and develop a plan to encourage active travel with supporting facilities. This resulted in the development of a new external cycle path on Odstock Road in conjunction with Wiltshire County Council during 2011. To follow on from this the Trust has run two cycle to work schemes for staff. Each of these saw a take up of around 30 cycles.

Traffic management: The Trust's objectives in this area are: to work with partners and stakeholders; develop plans to reduce traffic impacts; promote public transport and active travel supported with information and incentive schemes. As part of these objectives, the Trust has worked with a cycle company which enables staff cycles to be repaired and maintained on site while they are at work. This has been a private arrangement between the cycle owner and the company. Also, on site car parking is now strictly managed following the introduction of enforcement measures in May 2011.

Procurement

Policies and performance: Work is ongoing to develop a sustainable procurement policy that supports local community and minimizes environmental impacts.

Procurement skills: Work is ongoing to provide staff with accessible information on sustainable procurement; provide training and review the learning and development needs of staff against key sustainable development objectives.

Engaging suppliers: Work is ongoing to assess the impact of key suppliers on our sustainable development objectives and also create an understanding of our objectives and help improve their understanding of sustainable development. Sustainable procurement: We have added sustainable development clauses in tendering documents and contracts. When bids are evaluated we now include a Carbon Reduction Strategy and Sustainability weighting. The next stage is to benchmark the impact of C02 from a procurement perspective and agree an action plan to reduce this.

Facilities Management

Minimising waste: The Trust has as active campaign to recycle unused or unwanted office equipment and furniture through a scheme run by volunteers. This has proved very popular with staff and has directly reduced the waste to landfill from the site and in some cases avoided the cost of buying new equipment.

Energy and water usage: The Trust has made use of a government-backed loan scheme to invest in energy efficient equipment. These schemes include the replacement of an older Combined Heat and Power unit (CHP), with a modern unit which is twice the size. This generates half of the power for the site. Low energy lighting LED and water and steam controls have also been installed or upgraded.

Workforce

Healthy workplace: The trust objective is to provide incentives and facilities to promote active low carbon travel, healthy and sustainable food choices and regular exercise. The Trust has an on-site fully equipped leisure facility which promotes fitness programmes and healthy activities. Catering staff are building on existing links with local suppliers to increase use of fresh, locally sourced food and ingredients. Staff and trade unions are involved in developing initiatives to support healthy lifestyles and provide accessible areas for staff rest and reflection.

Community Engagement

Policy and performance: The Trust developed a community engagement action plan with clear social, economic and environmental objectives. The Trust continues to work in partnership with other bodies and links in with Sustainability South West, local government and climate change adaptation teams.

Community participation: The Trust has gathered views on sustainable development. In addition, local volunteers have started a ground-breaking initiative for the NHS forming voluntary equipment recycling and reclamation project. The aim is that this will continue to develop and expand in the 2012/2013 financial year. This links in with the Waste management group and plans are in place to involve Governors in 2012.

Healthy and sustainable food choices: Plans for healthy and sustainable food choices, a system to track sourcing, transportation, consumption and disposal of food and drink products is ongoing together with targets to increase healthy and sustainable food choices.

Assets and resources: A review of assets and resources available to share with local community (e.g. green or commercial space) and develop plans to maximise benefit to community is ongoing.

Facilities and New Buildings

Policies and performance: A review of building stock and the development of sustainable buildings strategy and communicate with key partners and suppliers took place in 2011/2012. A project review of the south side of the Salisbury District Hospital site is underway. A partnership with development companies is being sought to explore possibilities for this section of land.

Design: Work to minimise whole life costs of building and refurbishment projects through design has continued, with ongoing work to produce design briefs that encourage low carbon, low environmental impact proposals from suppliers and partners.

Approach to Equality and Diversity

We respect and value the diversity of our patients, their relatives and carers, and our staff and are committed to meeting the needs and expectations of the diverse communities we serve, providing high quality care.

The Trust has undertaken a considerable amount of work on Equality and Diversity (E&D), which helps improve better patient services and promote equality of opportunity for staff. The Equality and Diversity Steering Group reports to the Trust Board and determines the strategic direction on E&D, based on current legislation and national initiatives.

The group reports to the Trust Board twice a year on its work and progress against action plans and provides information on the make up of staff and patients The Trust also has several equality forums:

- REACH (Reaching Equality Aspiring Confident Hope) group for Black Asian Minority Ethnic (BAME) staff
- LGBT (Lesbian, Gay Bisexual and Transgender) forum for staff to discuss issues that relate to their employment experiences and hospital services
- Disability staff forum which covers disability issues and policies. For instance, the Trust has the 'Positive About Disabled' people 'two ticks standard' and has policies that apply to the recruitment, retention, training and development of staff with disabilities.

We have used the Equality Delivery System (EDS) to engage with local and national interest groups who have offered feedback and involvement in the Trust's EDS assessment.

Public Sector Equality Duties (PSED)

The Trust has to prepare and publish one or more objectives that help the organisation further the three aims of the Equality Duty. The Trust used the NHS equality assessment tool (EDS Equality Delivery System) to support the collection of evidence on equality practises and measure its progress for the different equality groups: age, gender, religion/or belief, sexual orientation, marriage/ civil partnership, race, disability, pregnancy and maternity, gender reassignment.

The Trust also carries out impact assessments to ensure that Trust policies, procedures, developments or activities do not have an unintentional adverse impact on patients or staff from equality groups.

The Trust is compliant with its PSED duties and has published its Equality Delivery System gradings, equality objectives and supporting documents. This can be found at www.salisbury.nhs.uk/about us/equality and diversity along with other E&D information.

Priorities and Targets Going Forward

We have adopted the EDS (Equality Delivery System) model and are working with local interest groups on four equality objectives for 2012. These ensure that:

- changes across services are discussed with staff and patients so transitions are made smoothly.
- patients and carers report positive experiences of their treatment and care, that they are listened to and respected and their privacy and dignity prioritised.
- staff are free from abuse, harassment, bullying or violence from both patients and their relatives and colleagues, with redress being open and fair to all.
- middle managers and other line managers motivate their staff to work within an environment free from discrimination

In addition we are also:

- updating our Equality Impact Assessments to the new Equality Analysis model;
- holding two events a year to highlight Equality and Diversity within the Trust.
- working with PPI (Public, Patient and Involvement) and the Director of Nursing to ensure we are meeting our equality objectives for patients and visitors.

- publishing a quarterly Equality and Diversity newsletter for internal and external organisations.

These priorities are regularly reviewed, monitored and measured through the Equality and Diversity Steering Group, which is chaired by a non-executive director of the Trust.

Staff Survey Report

Approach to Staff Engagement

The Trust has well established processes for staff communications and consultation and there is a good working relationship between Trust management, Trade Unions and staff. Regular communication through face to face briefings, the Intranet and publications are enhanced by topic based communications where and when appropriate. For instance, this year Trust staff have been involved in sessions about the NHS reforms. Trade union representatives are actively involved in discussions around the future financial challenges facing the Trust, as are staff themselves through a number of open events. These also provide opportunities to feedback ideas and comments. The Trust has an open and honest culture of involvement and engagement and effective feedback mechanisms for staff. In more general terms, staff are able to provide feedback through the monthly Cascade Brief, the Chief Executive's message and executive led 'quality and safety walk rounds', as well as the national staff survey. The 2011 staff survey included a measure of 'staff engagement' – a combination of questions relating to the ability of staff to contribute towards improvements, staff recommending the Trust as a place to work or receive treatment, and staff motivation at work. The Trust score placed it in the best 20% of acute Trusts.

Summary of performance – NHS Staff Survey

	2010/2011		2011/2012		Trust Improvement/ deterioration
Response rate	**Trust**	**National average**	**Trust**	**National Average**	
	57%	54%	59%	57%	2% Improvement

	2010/2011		2011/2012		Trust Improvement/ deterioration
Top 4 ranking scores	**Trust**	**National average**	**Trust**	**National Average**	
Support from immediate managers	3.66	3.61	3.78	3.61	0.12 Improvement

Percentage of staff suffering work related stress in last 12 months	25%	28%	24%	29%	1% Improvement
Impact of health and wellbeing on ability to perform work or daily activities	1.54	1.56	1.48	1.56	0.06 Improvement
Trust commitment to work life balance	3.47	3.39	3.53	3.36	0.06 Improvement

	2010/2011		**2011/2012**		**Trust Improvement/ deterioration**
Bottom 4 ranking scores	**Trust**	**National average**	**Trust**	**National Average**	
Percentage of staff working extra hours	65%	66%	69%	65%	4% Deterioration
Percentage of staff using flexible working options	61%	63%	58%	61%	3% Deterioration
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	72%	75%	73%	74%	1% Improvement
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	19%	15%	16%	16%	3% Improvement

In addition to the top and bottom ranking scores above, the Trust has made significant progress from the previous year in the following areas.

	2010/2011		2011/2012		Trust Improvement/ deterioration
Improving scores	**Trust**	**National average**	**Trust**	**National Average**	
Percentage of staff feeling valued by their work colleagues	72%	76%	80%	76%	8% Improvement
Percentage of staff agreeing that their role makes a difference to patients	87%	90%	91%	90%	4% Improvement
Percentage of staff having well structured appraisals in last 12 months	29%	33%	41%	34%	12% Improvement
Percentage of staff appraised in last 12 months	68%	77%	82%	81%	14% Improvement

None of the Trust's scores had deteriorated statistically significantly from the previous year.

Future Priorities and targets

National staff survey scores measure how the Trust performs in relation to other acute Trusts and in terms of staff perceptions. Scores are not absolute scales or targets of good or bad performance. However, following publication of the staff survey, the Trust has an action plan that focuses on five key areas for improvement, which are listed below. These will be monitored by the Trust Board, reported upon in Trust Board meetings held in public and measured through the 2012 staff survey.

Appraisals: Our results show us as having made significant improvements in our performance between 2010 and 2011 staff surveys, reflecting targeted work in this area that the Trust has undertaken during 2011. We are keen to continue to work to improve our performance in both the quality and quantity of appraisals, together with associated personal development plans - seeking to move our overall Trust performance to at least above average by the time of the next staff survey.

Experience of violence, harassment, bullying or abuse from staff, patients, relatives or the public in last 12 months, and perceptions of effective action from employer in relation to these issues: In these areas Trust performance has not improved over the last year, and although no worse than average for an acute Trust this is an area the Trust wishes to improve, in keeping with our Trust value of Respect. The Target for 2011/12 is to reduce the number of instances of violence, harassment, bullying or abuse, and to improve staff perceptions of the Trust taking effective action.

Satisfaction with the quality of work and patient care individuals feel able to deliver: Although there has been no significant change in our score since 2009 we remain 'below average' in this area when benchmarked against other acute Trusts. It is important that staff feel empowered and able to play their part and the target is to improve in this area to reach at least 'average' in this area by the 2012 staff survey.

Percentage of staff working extra hours: Although there has been no significant change in our score we are now in the 'worst 20%' in this area when benchmarked against acute Trusts. We need to understand more about the factors behind these results and at the very least ensure staff are not working an excessive number of hours.

Percentage of staff using flexible working options: We score below average for an acute Trust in this area and therefore we need to at least understand why, particularly as the Trust scores in the best 20% of acute Trusts for its commitment to work life balance.

Regulatory Ratings Report

Financial Rating

When assessing financial risk, Monitor will assign a risk rating using a scorecard which compares key financial metrics on a consistent basis across all NHS Foundation Trusts. These indicators are:

- achievement of plan
- underlying performance
- financial efficiency
- liquidity

The risk rating, on a scale of 1 to 5 with 5 representing the least risk and 1 the highest risk, is intended to reflect the likelihood of a financial breach of the Authorisation. The most common scores are 3 or 4. While the Trust has a sound record of financial management, it has had to bear the cost of extra drugs, services and additional activity, but has nevertheless achieved a rating of 3.

Governance Risk Rating

Monitor's assessment of governance risk is based predominantly on the Trust's plans for ensuring compliance with its Terms of Authorisation, but will reflect historic risk performance where this may be indicative of future risk.

The governance rating is determined by an assessment of five governance elements which are:

- performance against national measures
- compliance with third party requirements (Care Quality Commission, NHS Litigation Authority)
- declared risk of, or actual, failure to deliver mandatory services
- any other certification failures (not includes in bullet points I, 2 and 3 such as non cooperation with NHS bodies local authorities or the cooperation and competition panel)
- Any other factors not covered above that the regulator may regard as a breach of the Trusts terms of authorisation

NHS Trusts will, in general, supply the information that determines their governance risk rating. In particular they are responsible for self-certification on a quarterly basis on most areas of governance and for supplying any relevant exception reports. Further information on the finance and governance risk ratings can be found in Monitor's 2011/2012 Compliance Framework published on 31 March 2011. This can be found at: www.monitor-nhsft.gov.uk

Monitor assessed the Risk Rating against four measures - green, amber-green, amber-red and red. Each year the Trust submits an Annual Plan for agreement with Monitor in which the Trust forecasts its performance. The Trust then submits quarterly reports on which it is assessed by Monitor against the agreed plan. The Annual Plan forecast ratings and the quarterly performance against these ratings for 2010/11 and 2011/2012 are set out overleaf.

	Annual Plan 2010/2011	Q1 2010/2011	Q2 2010/2011	Q3 2010/2011	Q4 2010/2011
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Green	Amber-Green	Amber-Green	Green	Green

	Annual Plan 2011/2012	Q1 2011/2012	Q2 2011/2012	Q3 2012/2012	Q4 2011/2012
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Green	Amber-Green	Amber-Green	Amber-Green	Amber-Red

The Trust completed 2010/ 2011 with a Green Governance Risk Rating. However, in 2011/2012 the Trust failed to maintain this performance for two reasons. In July 2011 the Trust experienced an outbreak of c.difficile which resulted in a significant increase in confirmed cases. In response the Trust immediately carried out a Serious Incident Enquiry which found there was no direct link between the cases. However, the report made some recommendations that were endorsed by the Board, which included the implementation of an enhanced cleaning programme. Thereafter, the incidence of c.difficile declined, but the overall target for the year of 25 cases was breached. Following the outbreak, Monitor allocated the Trust an Amber - Green Risk Rating in Quarters 1, 2 & 3.

For 2011/ 2012 Monitor introduced additional cancer targets making five in total. In Quarter 4 the Trust narrowly failed to meet one of these targets. This was the quarterly target for Cancer 62 day wait for first treatment from a consultant screening service, when one patient had taken longer than expected to decide which pathway they wanted to follow after a positive screening at a different Trust. As the patient then decided they would like the follow-up treatment at Salisbury, a breach of the 62 target was shared between the Trust which screened the patient and Salisbury. Because of this Monitor awarded the Trust an Amber - Red Governance Risk Rating in Quarter 4. Please note that Trust still met its annual end of year target.

At no time since the Trust was authorised as a Foundation Trust on 1 June 2006 has Monitor had to formally intervene under any of the powers which are available to the Regulator.

Public Interest Disclosures

Partnership Working

The Trust works in partnership with other statutory, non statutory and voluntary sector organisations to commission and develop work to support diverse communities. Current work includes supporting the work of the South Wiltshire Diversity Partnership, which looks at the needs of local people so that there is an integrated approach to service planning. Working with SCAR (Salisbury Coalition against Racism) which raises awareness of racism and highlight the diverse nature of the local community. The Trust is also working with learning disability groups to improve these patients' and their carers' experiences of hospital care.

Occupational Health and Safety

Each member of staff has access to a comprehensive in-house Occupational Health Service that includes a full-time staff counsellor. The Trust has an active Health and Safety Committee, where management and staff Health and Safety representatives meet regularly to consider the Trust's performance against a range of indicators and to discuss actions and developments for improvement.

Policies and Procedures to Counter Fraud

As part of its communications with staff and the public, the Trust acknowledges that it has a responsibility to ensure that public money is spent appropriately and that it has policies in place to counter fraud and corruption. The Trust has detailed Standing Financial Instructions and a Counter Fraud and Corruption Policy to ensure probity. In addition, the Trust raises awareness of fraud in its staff communications and through displays in public and staff areas.

Better Payment Practice Code

Better Payment Practice Code		
	Number	**£000s/Amount**
Total Non-NHS trade invoices paid in the period	65,228	58,318
Total Non-NHS trade invoices paid within target	54,813	45,682
Percentage of Non-NHS trade invoices paid within target	84.0%	78.3%
Total NHS trade invoices paid in the period	2,274	4,847
Total NHS trade invoices paid within target	1,664	3,386
Percentage of NHS trade invoices paid within target	73.2%	69.9%
The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.		

Management Costs

Management Costs (excluding subsidiary)	
	£000
Total Trust Management Costs	6,489
Total Trust Income	182,688
% of total Income	3.55%

Size and Profitability of Income Generation Activities

The Trust provides a variety of services to patients, visitors, staff and external bodies that generate income which cover the cost of the service and makes a contribution towards funding patient care. Services that generate income include: accommodation, catering, laundry, car parking, private patient treatment, pharmacy products, sterile supplies, equipment, and professional health care advice. The total income from these areas amounted to just under £5 million. Some areas, such as day nursery and the Staff Club, aim to break even. The other areas contributed surpluses, which have been applied to meeting patient care expenditure

Patient and Public Involvement Initiatives

Patients were involved in over 40 projects this year, using many different methods including patient stories, focus groups, questionnaires real time feedback and the making of a film. Projects have been carried out within a wide range of wards and departments and have included close working with the Kings Fund Point of Care Project. This involved orthopaedics and cardiology. Work has also been undertaken with plastic surgery, rheumatology, outpatients departments, diabetes and anticoagulation, all of which have resulted in service improvements.

Policies Adopted with Suppliers

Tender specifications now require companies or individuals to disclose their approach to equality and diversity.

Sickness Absence Information

The Trust has robust procedures for the management of sickness absence with regular reporting at departmental, directorate and Trust Board level. For the 2011/2012 year the sickness absence rate was 3.48%. This represents an improvement from the previous year, which stood at 3.82 %.
As part of the formal annual reporting process, sickness absence data is provided quarterly to the cabinet office and figures for the period of January to December 2011 must also be published in the Annual Report in the following way.

- The total number of Full Time Equivalent (FTE) Days lost to sickness absence 20,683
- The total number of FTE years available 2,704
- Average number of days sickness absence per FTE 7.65

Compliance with HM Treasury and Office of Public Sector Information Guidance

Salisbury NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

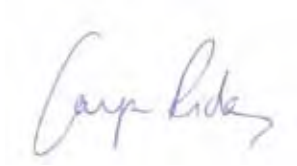
Serious Untoward Incidents involving data loss or confidentiality

During 2011/2012 there were no reported Serious Untoward Incidents involving data loss or confidentiality breaches.

Review of Effectiveness of Trust's System of Internal Control

The Trust Board has carried out a review of the effectiveness of its systems of Internal Control. This is covered in the Annual Governance Statement in the Annual Accounts.

The Annual Report has been approved by the Trust Board on 25 May 2012.



Caspar Ridley
Chief Executive
25 May 2012

Salisbury NHS Foundation Trust Consolidated Financial Statements For The Year To 31 March 2012

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FOREWORD TO THE ACCOUNTS

These consolidated accounts for the year ended 31 March 2012 have been prepared by Salisbury NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006, and comply with the annual reporting guidance for NHS Foundation Trusts within the NHS Foundation Trust Annual Reporting Manual (FT ARM) for the financial period.

Salisbury NHS Foundation Trust Annual Report and Accounts are presented to Parliament pursuant to Schedule 7 paragraph 25(4) of the National Health Service Act 2006.

The results of the Trust's subsidiary company, Odstock Medical Limited, for the year to 31 March 2012 and its assets and liabilities as at that date have been consolidated into these financial statements. Details of the subsidiary company can be found in note 32.

Signed:

Caspar Ridley - Chief Executive

Date: 25 May 2012

Statement of the Chief Executive's responsibilities as the Accounting Officer of Salisbury NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health Service Act 2006, Monitor has directed Salisbury NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- make judgements and estimates on a reasonable basis;

- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and

- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed:

Caspar Ridley - Chief Executive

Date: 25 May 2012

Annual Governance Statement

1. SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Salisbury NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide a reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Salisbury NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Salisbury NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

3. CAPACITY TO HANDLE RISK

As Accounting Officer I have overall responsibility for risk management but day to day management has been delegated to an Executive Lead for Risk. The Executive Lead for Risk is responsible for reporting to the Trust Board on the development and progress of risk management and for ensuring that the Risk Management Strategy is implemented and evaluated effectively. A Head of Risk Management supports the Executive Lead for Risk and is responsible for ensuring that staff are trained and equipped to manage risk in a way appropriate to their authority and duties. This is achieved through risk training programmes and through supporting and facilitating departments/teams directly, all underpinned by a comprehensive suite of risk management policies. The Head of Risk Management works closely with Directorate and General Management teams across the Trust to ensure they understand their responsibilities and accountabilities for managing risk in their areas. The approach is informed by various sources of information including incident reports, key quality indicator reports, survey feedback and comments, risk analysis exercises and central guidance. Areas of good practice are identified through the above intelligence which feeds into the Directorate performance meetings (3:3s). This mechanism allows the organisation to identify, learn from, and share good practice.

4. THE RISK AND CONTROL FRAMEWORK

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which provide assurance to the Board that the Trust is discharging its responsibilities as an NHS Foundation Trust in ensuring business and financial acumen, improving services and the quality of care provision, whilst operating as a model employer and service provider in achieving the Trust's operational and strategic objectives.

The Risk Management Strategy sets out the strategic goals towards which the Trust is working with regard to Risk Management and provides a framework that sets out clear expectations about the roles, responsibilities and requirements of all Trust staff.

The strategic goals are as follows: -

• To ensure the Trust remains within its licensing authorisation as defined by Monitor and to deliver a risk management framework which highlights to the Executive Team and Trust Board any risks which may prevent the Trust from complying with its licensing authorisation.

• Continued development of the Assurance Framework as the vehicle for informing the Statement in Internal Control.
• To ensure that Risk Management Policies are implemented ensuring that:
  > all risks, including principal risks, service development risks, and project risks, are being identified through a comprehensive and informed Risk Register and risk assessment process.
  > the open reporting of adverse events is encouraged and learning is shared throughout the organisation.
• To monitor the effectiveness of Risk Management Policies and procedures via the monitoring of agreed Key Performance Indicators.
• To further develop the organisational safety culture and its effectiveness through participation in the South West Improving Quality and Safety Programme and Executive Walk rounds.
• To develop an Annual Risk Management Plan, which is agreed, reviewed and monitored by the Trust Board.
• To ensure that all individuals within the organisation are aware of their role, responsibilities and accountability with regard to Risk Management.
• To ensure that the structure and process for managing risk across the organisation is reviewed and monitored annually.
• To ensure compliance with NHSLA Risk Management Standards, Monitor, Care Quality Commission registration requirements, and Health and Safety Standards.

The risk assessment and risk register procedure is set out within the Trust's Risk Management Policy. This policy gives clear singular instruction on the risk assessment process including risk identification, evaluation, treatment and monitoring. It also describes how risk assessments and the register are operationally managed through centralised Datix software and how the risks are communicated up and down the organisation. Directorate risk registers are reviewed at the Directorate performance meetings (3:3's) on a quarterly basis.

The Risk Management Policy makes it clear that it is not always possible to reduce an identified risk completely and it may be necessary to make judgements about achieving the correct balance between benefit and risk. In such instances a balance needs to be struck between the costs of managing a risk and the benefits to be gained.

A decision must therefore be made regarding the level which a risk would be deemed acceptable. A risk is considered acceptable when there are adequate control measures in place and the risk has been managed as far as is considered to be reasonably practicable. Risks requiring a cost benefit analysis are fed into the Trust Risk Register for wider debate and decision on 'acceptability' through the assurance committees.

Quality Governance Arrangements

Quality is clearly embedded in the Trust overall strategy and includes a number of goals:

• There will be a shared understanding of quality across the Trust.
• The achievement of quality is a core activity of all Trust staff who understand their individual roles and responsibilities.
• The Trust has a quality measurement system to support evaluation and improvement.

The overall Quality Strategy is supported by the Quality Directorate whose service plan includes objectives that drive year on year improvement across patient safety, clinical effectiveness and outcomes as well as patient experience in line with national and local priorities. The strategy is further supported by the annual quality report where the key priorities have been identified using for example quality performance information such as trends in reported incidents or patient survey results.

The Trust has established a quality framework for the review of individual services which includes completion of the Salisbury organisation trigger tool as well as full review and analysis of the quality performance information available - this includes the directorate quality indicator report, clinical audit results, patient feedback from surveys, real time feedback, complaints and compliments, as well as risk reporting. This information is discussed at the quarterly Directorate quality meetings and performance meetings, department/ward quality walks, and is presented annually by the Directorate Management teams as part of the assurance process to the Clinical Governance Committee.

There is a clear quality reporting structure in the Trust where scheduled reports are presented and discussed at the monthly Clinical Management Board (CMB) and/or the bi-monthly Clinical Governance Committee (CGC), and where appropriate, submitted to the Commissioners as part of the Trust contract performance compliance.

Any external agency/peer reviews during the year have the reports, recommendations and action plans discussed at one of the assuring committees and any identified are added to the Trust risk register.

Areas where risks have been identified through this approach, have agreed action taken/planned, which is then monitored through the Directorate 3:3 performance management framework. Any recurrent themes can be included as key objectives for improvement in the Trust service plan or future Quality Report priority areas.

The CQC assurance processes are clear. Following registration without conditions on 1 April 2010 each Outcome has been assigned to a Lead Manager and Executive Director who maintain an up to date Provider Compliance Assessment form which is subject to periodic review by an independent assuring committee. The independent assuring committees have this duty recorded in their Terms of Reference. The process and the individual Provider Compliance Assessment forms were overviewed by the Trust Board at the year end and this overview will continue to be undertaken on an annual basis. Any areas of concern would be included in the Trust risk register. The Trust's approach has also been evaluated by the internal auditors, South Coast Audit, and found to be satisfactory. The CQC's unannounced visit, which took place on 3 and 4 May 2011, audited the Trust's approach in 2011/12. Only a number of minor concerns were raised, these have been addressed by action plans submitted to the CQC.

The Assurance Framework

From 2004/05 all NHS bodies were required to sign a full Statement on Internal Control/Annual Governance Statement and have the evidence to support the statement. The Assurance Framework brings together this evidence.

The Assurance Framework is agreed annually by the Trust Board. The Framework identifies the principal risks facing the Trust and informs the Trust Board how each of these risks is being managed and monitored effectively. Each principal risk has an identified local risk manager who is responsible for managing the reporting on the overall risk, controls, gaps, and actions being taken to mitigate against the risk. The identified local risk manager is normally an Executive Director. Assurance Committees are also identified to assure the Trust Board that each principal risk is being monitored, gaps in controls identified and processes put into place to minimise the risk to the organisation.

The designated Assurance Committees of the Trust Board are the Clinical Governance Committee, the Finance Committee and the Joint Board of Directors.

In order for the Board to be able to evaluate the quality and robustness of the Assurance Framework and to have arrangements in place to keep it updated in light of evidence from reviews and actual achievements the Head of Risk Management attends the Assurance Committees to review and update the Assurance Framework on a quarterly basis. At these reviews the Trust Risk Register (risks scoring 12 and above - high and extreme) is also presented so that the assurance committees can consider the breadth and depth of information included, the robustness of agreed mitigating actions, and whether there are risks which may impact on the principle risks within the Assurance framework. The assurance committees can recommend inclusion of such risks on the assurance framework should there be sufficient concern as to their impact.

The Audit Committee, on behalf of the Trust Board, and Internal Audit formally review the Assurance Framework.

Aligned to the headings in the Trust Service Plan the assurance framework has identified in-year strategic risks around:

(i) Improving Safety - for example, compliance with infection control practices, compliance with patient safety standards, compliance with safeguarding requirements and compliance with Dementia standards. These are all being managed/mitigated through a comprehensive programme of controls and reporting arrangements such as monthly PEAT audits, implementation of the SFT Organisational Trigger Tool, ongoing close involvement with the regional safeguarding boards and the Trust Dementia Steering Group. Internal groups such as the Infection Control Committee, Clinical Risk Group, Safety Steering Group, Clinical Management Board, and Clinical Governance Committee assess the impact of the control measures and actions in place.

(ii) Service Improvement - for example integrated governance processes, performance ratings, centralisation of services, planning of activity, procurement of IT systems and meeting equality duties. Actions are in place to mitigate these risks which are monitored and evaluated through internal groups such as the Operational Management Board, Information Strategy Steering Group, and Joint Board of Directors who receive regular performance reports across these activities in order to consider adequacy of the actions in place. External monitoring is also in place with the Commissioning PCT and compliance with CQC outcomes.

(iii) Patient and Public involvement - for example involving people in the planning of services. National Patient Survey and Real Time Feedback reporting processes are utilised and actions are monitored through the Clinical Governance Committee.

(iv) Customer Care - for example the implementation of Choice. Referral patterns are monitored and reported through the Joint Board of Directors. As commissioning responsibilities change the Trust continues to explore collaborative working opportunities with primary care partners to improve the patient experience.

(v) Staff Wellbeing - for example ensuring the maintenance of an appropriately skilled workforce to maintain staff well being during the implementation of changes in organisational size and structure. Workforce plans are developed across the Trust to inform any service change. The staff well being project and a workforce redesign steering group is in place to focus on this area and outcomes/performance is monitored through the Joint Board of Directors.

(vi) Finance - for example securing income, meeting savings targets, budgetary control, efficiency of services, activity levels and cost reduction. These financial risks are mitigated through performance management of the Directorates with robust financial information available so that outcomes of actions can be assessed. The Programme Steering Group oversees the breadth of the organisations savings programme which have been clustered into several key schemes with performance indicators reported at each monthly meeting. Delayed transfer of care metrics are in place and progress is monitored at JBD. All financial information is ultimately reported up to the Finance Committee on a monthly basis.

As the organisation looks towards 2012/13, emerging risks will continue to be identified through the Annual Plan process as required by Monitor. In the current climate future risks to the organisation include, ongoing restructure of commissioning services external to the Trust and the potential impact of this, continued emphasis on cost reductions and savings plans, and the maintenance of a critical mass in some services. Emerging risks will also be identified from external review bodies. The recent Health and Safety Executive visits resulted in improvement notices in two emerging risk areas concerned with violence and aggression and the management of dermatitis.

These emerging risks will be managed and controlled within the established risk management framework which has been described above. Outcomes and effectiveness of controls/actions will be monitored through the assurance committees through performance reporting and the review of mitigation measures as detailed within the assurance framework and risk register.

The Trust recognises the importance of information assets and is committed to managing them through clear leadership and accountability underpinned by staff education. The Trust has identified a Senior Information Risk Owner (SIRO) at Board level to monitor and report on all information related risks. The Information Risk Policy defines how the Trust manages information risk and how the effectiveness of the policy is assessed and measured. The Information Risk Policy fits within the overall risk management framework for the Trust. It identifies the roles and responsibilities of the Information Asset Owners and Administrators who work with the SIRO to ensure that all information risks are identified and monitored through the Trust risk register and risk assessment processes.

During 2011/12 there has been a comprehensive and robust evidence assurance programme linked to the work of information asset management. The Trust continues to ensure that the Information Asset Owners and Information Asset Administrators evidence is reviewed and updated on a regular basis. Any changes to processes and procedures are appropriately documented, risk assessed and approved prior to implementation.

Information Governance arrangements within the organisation have continued to improve in 2011/12. All laptops have been encrypted, and all computers have been "locked down" so users cannot save data to unencrypted memory sticks.

A self assessment against version 8 of the IG toolkit has demonstrated improved compliance enabling an achievement of level 2 or 3 on all key requirements as per Monitor's expectations.

Another example of how risk management is embedded into organisational activity is illustrated through the policy ratification process. It is a requirement that all Trust policies have undergone equality impact assessment screening and where indicated, a full assessment.

Incident reporting is encouraged throughout the organisation under a single process described in the Adverse Events Reporting Policy. Numbers of incidents reported by professional group and department are monitored as a quality indicator within the risk management report cards at the directorate performance meetings. The 2011 staff survey showed that respondents were in the highest (top 20%) on reporting errors, the trust performed above average for staff in the fairness and effectiveness of the incident reporting procedures. The National Reporting and Learning System (NRLS) report (April 2011 - September 2011) showed that the Trust is in the top percentile for reporting of incidents.

Patient and public involvement projects have been active in considering risk issues, and have been engaged in some key pieces of work for example the public were involved in the redesign of signage within the Trust and the Equality Diversity Scheme was launched for external stakeholders. Key risk areas are also discussed, where appropriate, through Governors meetings and Constituency meetings with the membership.

The Trust is fully compliant with the requirements of registration with the Care Quality Commission. The Trust was granted registration with the Care Quality Commission from 1st April 2010 without conditions and this continues. The unannounced visit by the CQC Inspectors on 3rd and 4th May 2011 identified only minor concerns. These have been addressed by action plans submitted to the CQC.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control Measures are in place to ensure that all the organisation's obligations under equality, diversity, and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on the UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

The Trust regularly reviews the economy, efficiency, and effectiveness of the use of resources through: benchmarking, reference costs, regular meetings between the Directorates and Executive Directors, and assessing performance against plans. Investments are determined against detailed business plans and outcomes are reviewed against those plans.

The Trust Board, through its Sub-Committee the Finance Committee, reviews performance against savings plans and the delivery of efficient services within budget.

A Programme Steering Group has been established to drive forward savings across the Trust. Membership comprises the Executive Directors, Directorate Managers and other senior staff within the organisation. The Group has assisted in achieving a significant proportion of the savings target for 2011/12 and will continue its work in 2012/13. A systematic approach is used to monitor performance based on the work performed at the Trust by external consultants.

The Trust has also been successful in achieving cost savings through service improvement projects, which continue to optimise the efficient and effective use of resources whilst enhancing the patient experience. This is exemplified by the Enhanced Recovery Programme.

Procurement of goods and services is undertaken through professional procurement staff and through working with neighbouring organisations within a Procurement Confederation. The cost of goods is regularly benchmarked.

In year cost pressures are rigorously reviewed and challenged, and means of avoiding cost pressures are always considered.

Internal Audit is used to ensure resources are used effectively.

The Trust's Reference Costs shows it to be approximately 7% below the national average costs, based on the last published data, which relates to 2010/11.

6. ANNUAL QUALITY REPORT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

To ensure that the Quality Report presents a balanced view and there are appropriate controls in place to ensure accuracy of data the following steps are taken:

• The Trust has a Quality Strategy in place which informs the organisation's direction of travel taking into account local and national priorities.

• There is clear corporate leadership for Quality. The Medical Director and Director of Nursing lead on the areas of work identified within the Quality Report.

• Progress against the priority areas within the Quality Report is monitored through the clinical governance framework and selected quality metrics are reported via the Quality Indicator report which is published every month for the Trust Board and Clinical Management Board.

• There is corporate leadership for data accuracy with the Director of Corporate Development holding responsibility for the quality of performance data which is reported monthly at the Joint Board of Directors and Trust Board.

• The Trust has a Data Quality Policy in place (underpinned by documented department based administrative processes) which detail the steps taken to ensure data accuracy.

• Data Quality features within the roles and responsibilities (job descriptions) of key staff members for example those working in the Information Department.

• The Quality Report process is coordinated by the Head of Clinical Effectiveness and Deputy Director of Nursing. There is an established timetable of stakeholder engagement including staff, governors, and membership. A wide range of methods have been utilised to gather information, and input in order to inform the priority areas. This includes the use of national inpatient surveys, real time feedback in clinical areas, risk reports, issues raised through executive led Safety and Quality walk rounds. The priorities have been discussed with clinical teams as part of the service planning process, and views from staff, Trust Governors, and the membership have been sought. Local GPs have been asked for their feedback and the Quality Report is reviewed by our readership panel to ensure ease of reading for the lay person.

• The Quality Report is only published following the above timetabled reviews and data scrutiny by internal and external stakeholders including the Audit Commission.

7. REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Finance Committee, Clinical Governance Committee, and Joint Board of Directors and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit has provided me with an opinion of significant assurance given that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently. The main reason for this decision was the significant level of assurance that we could provide over all the Trust's key financial systems and robust arrangements in place for the Assurance Framework and Risk Management processes. However, some weaknesses in the design of controls and/or inconsistent application have been identified in the Internal Audit Annual Report. These include the Clinical Governance Framework, in particular the following up of action plans with allocated officers. Other areas identified in the 2011/12 report include Consultant job planning. Information Governance (Computer Audit review) and Software Asset Management. Action plans have been put in place to address these, monitored by the Audit Committee.

Executive Managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. Other sources of assurance on which reliance has been placed include the external audit opinion (The Audit Commission), the assurance committees (including the Audit Committee), the self assessment process against the CQC essential standards of quality and safety (unannounced visit May 2011), NHSLA Risk Management assessments (revalidation of Level 2 achieved in April 2011 for a further 3 years), South Coast Audit and the Internal Clinical Audit Team who have provided me with information and comments.

8. CONCLUSION

Overall there is in place a dynamic process for the management of internal control which is reviewed and updated regularly by the Executive Team and various Board Committees that are in place in the Trust to help me meet my responsibilities as Accounting Officer. I conclude that no significant internal control issues have been identified for the year ended 31st March 2012.

Signed:

Caspar Ridley
Chief Executive

Date: 25 May 2012

Independent Auditor's report to the Council of Governors of Salisbury NHS Foundation Trust

I have audited the financial statements of Salisbury NHS Foundation Trust for the year ended 31 March 2012 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Council of Governors of Salisbury NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work was undertaken so that I might state to the Council of Governors those matters I am required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and Auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion:

- give a true and fair view of the state of affairs of Salisbury NHS Foundation Trust as at 31 March 2012 and of its income and expenditure for the year then ended; and

- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and

- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I report to you, if in my opinion the Annual Governance Statement does not reflect compliance with Monitor's requirements. I have nothing to report in this respect.

Certificate

I certify that I have completed the audit of the accounts of Salisbury NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Simon Garlick

Engagement Lead
Audit Commission
Collins House
Bishopstoke Road
Eastleigh
Hampshire
SO50 6AD

Date: 29 May 2012

STATEMENT OF COMPREHENSIVE INCOME
For The Year Ended 31 March 2012

		Group		Trust	
			Restated		Restated
		2011/12	2010/11	**2011/12**	2010/11
	Note	**£000**	£000	**£000**	£000
Revenue from patient care activities	3	**168,330**	161,794	**168,330**	161,794
Other operating revenue	5	**16,195**	18,397	**14,694**	16,914
Operating expenses	7	**(178,252)**	(172,987)	**(176,779)**	(171,540)
OPERATING SURPLUS		**6,273**	7,204	**6,245**	7,168
FINANCE COSTS					
Finance income	12	**172**	105	**172**	105
Finance costs - financial liabilities	13	**(1,838)**	(1,819)	**(1,838)**	(1,819)
Finance costs - unwinding of discount on provisions	13	**(16)**	(13)	**(16)**	(13)
PDC Dividends payable		**(3,452)**	(3,566)	**(3,452)**	(3,566)
NET FINANCE COSTS		**(5,134)**	(5,293)	**(5,134)**	(5,293)
Corporation tax expense		**-**	(7)	**-**	-
RETAINED SURPLUS FOR THE YEAR		**1,139**	1,904	**1,111**	1,875
OTHER COMPREHENSIVE INCOME					
Revaluation gains/(losses) on property plant and equipment	17	**(5,179)**	8,132	**(5,179)**	8,132
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**(4,040)**	10,036	**(4,068)**	10,007
NOTE: ALLOCATION OF PROFIT/(LOSSES) FOR THE YEAR					
(a) Surplus/(Deficit) for the period attributable to:					
(i) Minority interest, and		**10**	9	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**1,129**	1,895	**1,111**	**1,875**
TOTAL		**1,139**	1,904	**1,111**	**1,875**
(b) Total comprehensive income/(expense) for the year attributable to:					
(i) Minority interest, and		**10**	9	**-**	-
(ii) Owners of Salisbury NHS Foundation Trust		**(4,050)**	10,027	**(4,068)**	10,007
TOTAL		**(4,040)**	10,036	**(4,068)**	10,007

The notes on pages 5 to 34 form part of these financial statements.

All revenue and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION
31 MARCH 2012

		Group			Trust		
			Restated	Restated		Restated	Restated
		31 March	31 March	1 April	**31 March**	31 March	1 April
		2012	2011	2010	**2012**	2011	2010
	Note	**£000**	£000	£000	**£000**	£000	£000
NON-CURRENT ASSETS							
Intangible assets	16	**284**	86	-	**284**	86	-
Property, plant and equipment	17	**130,061**	137,665	126,442	**130,041**	137,627	126,394
Investments in subsidiaries	32	**-**	**-**		**-**	-	
Total non-current assets		**130,345**	137,751	126,442	**130,325**	137,713	126,394
CURRENT ASSETS							
Inventories	18	**2,517**	2,263	1,698	**2,457**	2,179	1,643
Trade and other receivables	19	**7,567**	13,313	11,041	**7,523**	13,274	11,016
Cash and cash equivalents	20	**21,058**	10,040	10,193	**20,880**	9,915	10,039
Total current assets		**31,142**	25,616	22,932	**30,860**	25,368	22,698
Total assets		**161,487**	163,367	149,374	**161,185**	163,081	149,092
CURRENT LIABILITIES							
Trade and other payables	21	**(19,789)**	(16,411)	(12,030)	**(19,693)**	(16,303)	(11,897)
Borrowings	22	**(2,263)**	(2,165)	(1,262)	**(2,263)**	(2,165)	(1,262)
Provisions	23	**(1,065)**	(331)	(325)	**(1,065)**	(331)	(325)
TOTAL CURRENT LIABILITIES		**(23,117)**	(18,907)	(13,617)	**(23,021)**	(18,799)	(13,484)
TOTAL ASSETS LESS CURRENT LIABILITIES		**138,370**	144,460	135,757	**138,164**	144,282	135,608
NON-CURRENT LIABILITIES							
Borrowings	22	**(23,595)**	(25,618)	(26,971)	**(23,595)**	(25,618)	(26,971)
Provisions	23	**(307)**	(334)	(362)	**(307)**	(334)	(362)
TOTAL NON CURRENT LIABILITIES		**(23,902)**	(25,952)	(27,333)	**(23,902)**	(25,952)	(27,333)
TOTAL ASSETS EMPLOYED		**114,468**	118,508	108,424	**114,262**	118,330	108,275
FINANCED BY:							
TAXPAYERS' EQUITY							
Minority Interest		**67**	57	48	**-**	-	-
Public dividend capital		**51,229**	51,229	51,181	**51,229**	51,229	51,181
Revaluation reserve		**52,260**	58,628	51,302	**52,260**	58,628	51,302
Income and expenditure reserve		**10,912**	8,594	5,893	**10,773**	8,473	5,792
TOTAL TAXPAYERS EQUITY		**114,468**	118,508	108,424	**114,262**	118,330	108,275

The notes on pages 5 to 34 form part of these financial statements.

The financial statements on pages 1 to 34 were approved by the Board on 25 May 2012 and signed on its behalf by:

Signed:

Caspar Ridley - Chief Executive

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS EQUITY
31 MARCH 2012

	Public dividend capital (PDC)	Income and expenditure reserve	Revaluation reserve	Donated asset reserve	Minority interest	Total taxpayers' equity
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2010	**51,181**	**4,749**	**51,302**	**1,144**	**48**	**108,424**
Prior Period Adjustment	**-**	**1,144**	**-**	**(1,144)**	**-**	**-**
Balance at 1 April 2010 - restated	**51,181**	**5,893**	**51,302**	**-**	**48**	**108,424**
Changes in taxpayers' equity for 2010-11						
Net gain/(loss) on revaluation of property plant and equipment			8,132	-		**8,132**
Retained surplus/(deficit) for the year		1,895			9	**1,904**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		806	(806)			**-**
Transfers of realised profits/(losses) to the income and expenditure reserve		-	-	-		**-**
Transfers between reserves						**-**
Other recognised gains and losses		-				**-**
Public dividend capital received in year	48					**48**
Public dividend capital repaid in year	-					**-**
Balance at 31 March 2011	**51,229**	**8,594**	**58,628**	**-**	**57**	**118,508**
Changes in taxpayers' equity for 2011-12						
Net gain/(loss) on revaluation of property plant and equipment			(5,179)	-		**(5,179)**
Retained surplus/(deficit) for the year		1,129			10	**1,139**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		1,189	(1,189)			**-**
Transfers of realised profits/(losses) to the income and expenditure reserve		-	-			**-**
Transfers between reserves						**-**
Other recognised gains and losses		-				**-**
Public dividend capital received in year	-					**-**
Public dividend capital repaid in year	-					**-**
Balance at 31 March 2012	**51,229**	**10,912**	**52,260**	**-**	**67**	**114,468**

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2012

	Note	2012 £000	Restated 2011 £000
CASH FLOWS FROM OPERATING ACTIVITIES			
Total operating surplus		**6,273**	7,204
NON-CASH INCOME AND EXPENSE			
Depreciation and amortisation charge		**8,475**	7,744
Dividends accrued and not paid or received		**298**	-
(Increase)/decrease in trade and other receivables		**5,746**	(2,272)
(Increase)/decrease in inventories		**(254)**	(565)
Increase/(decrease) in trade and other payables		**3,321**	3,264
Increase/(decrease) in provisions		**707**	(22)
Tax (paid)/received		**(7)**	(26)
Other movements in operating cash flows		**-**	(557)
Net cash inflow from operating activities		**24,559**	14,770
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		**172**	105
Payments to acquire property, plant and equipment		**(6,032)**	(11,736)
Receipts from sale of property, plant and equipment		**-**	1,465
Payments to acquire intangible assets		**(216)**	(92)
Net cash inflow/(outflow) from investing activities		**(6,076)**	(10,258)
CASH FLOWS FROM FINANCING ACTIVITIES			
New public dividend capital received		**-**	48
Loans repaid		**(1,528)**	(746)
Loans received		**500**	1,959
Capital element of finance lease rental payments		**(78)**	(73)
Capital element of Private Finance Initiative obligations		**(614)**	(596)
Interest paid		**(92)**	(96)
Interest element of finance lease rental payments		**(39)**	(44)
Interest element of Private Finance Initiative obligations		**(1,723)**	(1,692)
PDC dividend paid		**(3,891)**	(3,425)
Net cash (outflow)/inflow from financing		**(7,465)**	(4,665)
(Decrease)/increase in cash and cash equivalents		**11,018**	(153)
Cash and cash equivalents at the beginning of the financial year		**10,040**	10,193
Cash and cash equivalents at the end of the financial year	20	**21,058**	10,040

A separate cash flow for the Trust has not been prepared as the amounts involved are not significantly different to that of the Group as a whole.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Basis of Consolidation

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to the minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

Where subsidiaries accounting policies are not aligned with those of the Trust (including where they report under UK Gaap) then amounts are adjusted during consolidation where the differences are material.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less cost to sell'.

NHS charitable funds considered to be subsidiaries are excluded from consolidation in accordance with the accounting direction issued by Monitor.

Unless otherwise stated the notes to the accounts refer to the group and not the Trust, as the Trust's balances are not materially different.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Income Recognition

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided, however, inpatient income is recognised in the accounts based on completed spells. Where income is received for a specific activity which is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment. Accruals at 31 March 2012 are based on estimates of invoices where services/goods were received but not invoiced at the year end. Included within these accruals is an estimated sum to cover invoices in the coming year where specific liabilities at 31 March 2012 had not been identified.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Internally generated
Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Software
Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'Other comprehensive income'.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits, which is as follows:
Software 5 Years

1.6 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Property, plant and equipment (continued)

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
● Land and non-specialised buildings – market value for existing use.
● Specialised buildings – depreciated replacement cost until 31 March 2012, when the assets were valued at modern equivalent value.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is derecognised.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. All other assets are being depreciated as follows:
Buildings (excluding dwellings) 2 - 59 years
Dwellings 34 - 67 years
Plant and Machinery 5 - 43 years
Transport equipment 5 - 10 years
Information Technology 4 - 10 years
Furniture and Fittings 5 - 25 years

Property, plant and equipment which has been reclassified as ' held for sale' ceases to be depreciated upon the reclassification.

Revaluation gains and losses
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease previously recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

1.6 Property, plant and equipment (continued)

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'Other comprehensive income'.

Each year the Trust makes a transfer from the Revaluation Reserve to the Income and Expenditure Reserve to reflect the excess of current cost depreciation over historical cost depreciation.

Impairments
In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where at the time of the original impairment, a transfer was made from the revaluations reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'Held for sale' once all of the following criteria are met:
- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within twelve months of the date of classification as 'held for sale';
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are derecognised when all material sale contract conditions have been met. Fair value is opening market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ' held for sale' and instead is retained as an operational asset and the assets economic life is adjusted. The asset is derecognised when scrapping or demolition occurs.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Property, plant and equipment (continued)

Donated, government grant and other grant funded assets
Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated. The surplus for the year to 31 March 2011 has been increased as a result of crediting donations in that year to income. Income in 2010-11 has also been reduced to remove the sum previously released from the donation reserve to offset donated depreciation in the year. As a result of these two amendments, both the income and surplus in the year to 31 March 2011 increased by £1,869,000. The balance on the donation reserve at 1 April 2010 of £1,144,000 was transferred to the income and expenditure reserve at that date.

Private Finance Initiative (PFI) transactions
HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Property, plant and equipment (continued)

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.7 Investment

Investments in subsidiary undertakings, associates and joint ventures are treated as fixed asset investments and stated at cost.

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cash flow statement.

1.8 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured on the First In, First Out (FIFO) method. Work-in-progress comprises goods in intermediate stages of production. The Laundry stock value is based on the original cost less an adjustment to reflect usage, over a three year life (except for Towels and Nightwear which have a two year life), in determining an approximation of net realisable value.

At the end of the financial year, the Trust decided to cease performing laundry work for hotels. As a result, an adjustment was made to fully write down the value of hotel stock items specifically related to that industry. Generic items were also reduced in value to an approximation of their continuing worth to the Trust.

1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and form an integral part of the Trust's cash management.

1.11 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the HM Treasury's discount rate of 2.2% in real terms except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 23, but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when the liability arises.

1.12 Employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as a defined contribution scheme.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.12 Employee benefits (continued)

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Subsidiary pension scheme

The subsidiary company (Odstock Medical Limited) operates a defined contribution scheme for employees who have contracts of employment directly with the company. Employer's pension costs are charged to operating expenses as and when they become due.

1.13 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.14 Corporation Tax

The trust does not have a corporation tax liability for the year 2011/12. Tax may be payable on activities described below:

- The activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA.
- The activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax.
- Annual profits from the activity must exceed £50,000

The Corporation Tax sum shown for the year 2010/11 relates to the Trust's subsidiary company.

1.15 Foreign Exchange

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2012. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.16 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury Financial Reporting Manual, see note 30.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.17 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

The trust leases land to Salisbury District Hospital Charitable Fund at a nominal amount and, as a result, no separate disclosure has been made of this arrangement.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.18 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Government Banking Service (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast

1.19 Losses and Special Payments

Losses and Special Payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.20 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.21 Financial assets

Financial assets are recognised when the trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification
Financial assets are classified into the following categories: financial assets at fair value through income and expenditure; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through income and expenditure
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method and credited to the Statement of Comprehensive Income.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.21 Financial assets (continued)

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

1.22 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

NOTES TO THE ACCOUNTS

2. Segmental Analysis

Group and Trust

The business activities of the Group can be summarised as that of 'healthcare'. The Trust's activities comprise five key operating areas or segments, where costs are closely monitored during the year. Income is not allocated to each area of activity. The chief operating decision maker for Salisbury NHS Foundation Trust is the Trust Board. Key decisions are agreed at monthly Board meetings and sub-committee meetings of the Board, following scrutiny of performance and resource allocation. The Trust Board review and make decisions on activity and performance of the Trust as a whole entity, not for its separate business activities. The activities of the subsidiary company, Odstock Medical Limited, are not considered sufficiently material to require separate disclosure.

3 Revenue

Group and Trust

3.1 Revenue by Type

	2012	2011
	£000	£000
Elective revenue	**37,165**	36,195
Non-elective revenue	**63,143**	62,444
Outpatient revenue	**27,837**	28,161
A & E revenue	**4,565**	4,089
Other types of activity revenue	**30,536**	23,381
Total revenue at full tariff	**163,246**	154,270
Revenue from activities		
Private patient revenue	**1,632**	1,387
Other non-protected clinical revenue	**3,452**	6,137
	168,330	161,794

Other types of activity revenue above includes amounts due for specialist services (e.g. spinal, burns, genetics, cleft lip and palate), direct access, intensive care, community and hospice services.

3.2 Revenue by Source

	2012	2011
	£000	£000
Foundation Trusts	**2,552**	839
NHS Trusts	**1,006**	1,141
Strategic Health Authorities	**-**	129
Primary Care Trusts	**159,705**	155,424
Local Authorities	**13**	-
Department of Health - grants	**-**	-
Department of Health - other	**-**	-
NHS Other	**88**	41
Non NHS:		
- Private patients	**1,632**	1,387
- Overseas patients (non-reciprocal)	**58**	23
- NHS Injury scheme (was Road Traffic Act)	**1,306**	1,088
- Other	**1,970**	1,722
	168,330	161,794

NHS Injury Scheme revenue is subject to a provision for doubtful debts of 10.5% to reflect expected rates of collection. Other income includes £1.6m income from Salisbury Hospicecare Trust.

3.3 Mandatory Services

Under its Terms of Authorisation the Trust is required to provide the mandatory services, the allocation of operating revenue between mandatory services and other services is provided in the table below:

	2012	2011
	£000	£000
Mandatory services	**163,246**	155,617
Non-mandatory services	**5,084**	6,177
	168,330	161,794

NOTES TO THE ACCOUNTS

4. Private Patient Revenue

Group and Trust	Base year 2002/03 £000	**2012 £000**	2011 £000
Private patient revenue	1,098	**1,632**	1,387
Total patient related revenue	90,173	**168,330**	161,794
Proportion (as a percentage)	1.2%	**1.0%**	0.9%

Section 44 of the 2006 Act requires that the proportion of private patient revenue to the total patient related revenue of NHS Foundation Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03 or the base year.

Following a High Court Judgement in December 2009, Monitor revised its rules on how the Private Patient Income Cap should be operated by Foundation Trusts from 1 April 2010. The Decision provided greater clarity on how the private patient charges provisions of Section 44 of the 2006 Act should be interpreted and applied. The Trust's Private Patient Income disclosure for the current year is based on the 2011/12 Foundation Trust Annual Reporting Manual (FT ARM) issued by Monitor.

5. Other Operating revenue

Group	**2012 £000**	Restated 2011 £000
Research and development	**1,311**	1,185
Education and training	**5,071**	5,293
Charitable and other contributions to expenditure	**336**	2,052
Non-patient care services to other bodies	**1,268**	1,536
Profit on disposal of property	**-**	588
Profit on disposal of plant and equipment	**-**	-
Other	**8,209**	7,743
	16,195	18,397

Included within 'Other' revenue above are amounts received from lodgings £1.1m, car parking £1.1m, catering £0.9m, laundry £1.4m, child care services £0.5m and trading revenue of the Trust's subsidiary company £1.5m.

6. Revenue

Total revenue is almost exclusively from the supply of services. Revenue from the sale of goods is immaterial.

NOTES TO THE ACCOUNTS

7. Operating Expenses

Operating expenses comprise:

Group	**2012**	2011
	£000	£000
Services from other NHS Foundation Trusts	**1,007**	232
Services from NHS Trusts	**568**	1,103
Services from PCT's	**831**	597
Services from other NHS bodies	**170**	51
Purchase of healthcare from non-NHS bodies	**836**	2,172
Executive directors costs	**911**	876
Non-executive directors costs	**146**	149
Staff costs	**112,591**	113,152
Drug costs	**11,738**	10,811
Supplies and services - clinical (excluding drug costs)	**19,041**	16,151
Supplies and services - general	**2,943**	2,742
Establishment	**2,029**	1,981
Transport	**604**	629
Premises	**7,858**	6,223
Provision for impairment of receivables	**120**	770
Increase in other provisions	**763**	-
Depreciation and amortisation	**8,475**	7,744
Loss on disposal of plant and equipment	**-**	31
Audit services - statutory audit	**72**	74
Other auditors remuneration	**-**	12
Clinical negligence	**3,002**	2,839
Other	**4,547**	4,648
	178,252	172,987

The total employer's pension contributions are disclosed in note 9.1.

Redundancy payments totalling £0.1m are included in staff costs and further details are disclosed in note 9.4.

Other expenses include payments for course fees £0.3m, patient's travel £0.1m, the service element of the PFI contract £0.6m, consultancy fees £0.3m, insurance fees £0.1m, legal fees £0.1m, internal audit fees £0.2m, contracted out services £0.1m and costs attributable to the Trust's subsidiary company £1.5m.

8. Operating leases

Group and Trust

8.1 As lessee

The Group has entered into commercial leases on certain items of property, motor vehicles and equipment. The principal arrangements are in respect of motor vehicles. For these, rentals are for an agreed mileage over a three year term. Excess mileage is charged at a price per mile determined at the inception of the lease.

8.2 Payments recognised as expense

	2012	**2011**
	£000	**£000**
Minimum lease payments	**215**	339

8.3 Total future minimum lease payments

	2012	2011
Payable:	**£000**	£000
Within 1 year	**128**	95
Between 1 and 5 years	**213**	31
After 5 years	**65**	25
Total	**406**	151

NOTES TO THE ACCOUNTS

9. Staff costs and numbers

9.1 Staff costs

Group	**Total 2012 £000**	Permanently Employed 2012 £000	Other 2012 £000	Total 2011 £000	Permanently Employed 2011 £000	Other 2011 £000
Salaries and wages	**93,462**	93,462	-	93,088	93,088	-
Social Security Costs	**6,852**	6,852	-	6,941	6,941	-
Employer contributions to NHSPA	**10,759**	10,759	-	10,767	10,767	-
Other pension costs	**-**	-	-	-	-	-
Agency and contract staff	**2,720**	-	2,720	3,232	-	3,232
	113,793	111,073	2,720	114,028	110,796	3,232

9.2 Average number of persons employed - WTE basis

Group	**Total 2012 Number**	Permanently Employed 2012 Number	Other 2012 Number	Total 2011 Number	Permanently Employed 2011 Number	Other 2011 Number
Medical and dental	**347**	336	11	338	322	16
Ambulance staff	**14**	14	-	15	15	-
Administration and estates	**595**	593	2	610	608	2
Healthcare assistants & other support staff	**218**	209	9	269	261	8
Nursing, midwifery & health visiting staff	**1,250**	1,208	42	1,240	1,197	43
Scientific, therapeutic and technical staff	**393**	392	1	442	437	5
Total	**2,817**	2,752	65	2,914	2,840	74

The figure shown under the 'Other' column relates to agency staff, disclosed under the operational areas where they worked.

9.3 Directors' Remuneration

	2012 £000	2011 £000
Salaries and wages	**869**	830
Social Security Costs	**87**	89
Employer contributions to Pension Schemes	**101**	106
	1,057	1,025

The total number of Directors accruing benefits under pension schemes is 6 (2011: 6)

9.4 Staff departure costs

	2012 No. of compulsory redundancies	**2012 No. of other agreed departures**	**2011 No. of compulsory redundancies**	**2011 No. of other agreed departures**
Exit package cost band				
< £10,000	**2**	**5**	-	-
£10,001 - £25,000	**1**	**4**	5	-
£25,001 - £50,000	**-**	**2**	1	-
£50,001 - £100,000	**1**	**-**	-	-
Total number of exit packages by type	**4**	**11**	6	-
	£000	**£000**	£000	£000
Total resource costs	**78**	**148**	108	-

There were no redundancy costs relating to senior managers in the year.

During the year, the Trust operated a Mutually Agreed Resignation Scheme (MARS) based on a Treasury approved scheme. Staff could put themselves forward for MARS and, if the Trust accepted their resignation, recompense was paid based on their salary and length of service, in line with the scheme rules. These payments are disclosed under 'other agreed departures' above.

NOTES TO THE ACCOUNTS

10 Pension costs

The total cost charged to income in respect of the Group's obligations to the NHS Pension Agency and the defined contribution scheme for Odstock Medical Limited was £10,759,000 (2011: £10,767,000). As at 31 March 2012, contributions of £1,358,000 (2011: £1,319,000) due in respect of the current reporting period (representing the contributions for the final month of the year) had not been paid over to the schemes by the balance sheet date.

10.1 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions . The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that 'the period between formal valuations shall be four years, with approximate assessments in intervening years'. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates. The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ended 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 march 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. in undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pensions Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

NOTES TO THE ACCOUNTS

10.1 Pension costs (continued)

Annual Pensions

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

11. Retirements due to ill-health

During the year to 31 March 2012 there were 4 (2011: 5) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £315,000 (2011: £107,000). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

NOTES TO THE ACCOUNTS

12. Finance income

Group	2012 £000	2011 £000
Interest revenue:		
Bank accounts	**172**	105
Other loans and receivables	**-**	-
	172	105

13. Finance costs

Group and Trust	2012 £000	2011 £000
Interest on loans from Foundation Trust Financing Facility	**76**	83
Interest on obligations under finance leases	**39**	44
Finance costs on obligations under Private Finance Initiatives	**1,425**	1,460
Contingent finance costs	**298**	232
Total finance expense - financial liabilities	**1,838**	1,819
Other finance costs - unwinding of discounts on provisions	**16**	13
Total	**1,854**	1,832

14. The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts payable arising from claims made by businesses under this legislation (2011: £Nil).

15. Losses and special payments

	2012		2011	
Group and Trust	**Number**	**Value £000**	Number	Value £000
Losses	**522**	**57**	364	64
Special payments	**38**	**36**	41	48
Total losses and special payments	**560**	**93**	405	112

There were no case payments that exceeded £100,000.

16. Intangible Assets - Group

16.1 Intangible assets at the balance sheet date comprise the following elements:

	Software Licences £000	Total £000
Cost or valuation		
At 1 April 2011	92	92
Additions - purchased	216	216
At 31 March 2012	**308**	**308**
Amortisation		
At 1 April 2011	6	6
Provided during the period	18	18
Amortisation at 31 March 2012	**24**	**24**
Net book value at 31 March 2011		
- Purchased at 31 March 2011	86	86
- Donated at 31 March 2011	-	-
Total at 31 March 2011	**86**	**86**
Net book value at 31 March 2012		
- Purchased at 31 March 2012	284	284
- Donated at 31 March 2012	-	-
Total at 31 March 2012	**284**	**284**

17. Property, plant and equipment

Group

17.1 Property, Plant and equipment at the balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2011	4,938	97,100	5,715	6,342	49,267	661	12,455	1,040	177,518
Additions - purchased	-	960	12	1,549	2,570	35	375	195	5,696
Additions - donated	-	15	-	-	242	-	5	74	336
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	3,062	33	(5,896)	1,060	-	1,405	336	-
Revaluation	-	(9,564)	(45)	-	-	-	-	-	(9,609)
Disposals	-	-	-	-	(7)	-	-	-	(7)
At 31 March 2012	**4,938**	**91,573**	**5,715**	**1,995**	**53,132**	**696**	**14,240**	**1,645**	**173,934**
Accumulated depreciation									
At 1 April 2011	-	-	-	-	29,763	633	8,907	550	39,853
Provided during the period	-	4,300	130	-	2,879	6	1,074	68	8,457
Revaluation	-	(4,300)	(130)	-	-	-	-	-	(4,430)
Disposals	-	-	-	-	(7)	-	-	-	(7)
Accumulated depreciation at 31 March 2012	**-**	**-**	**-**	**-**	**32,635**	**639**	**9,981**	**618**	**43,873**
Net book value at 31 March 2011									
Owned	4,938	74,941	5,715	5,515	17,229	28	3,490	490	112,346
Finance leased	-	-	-	-	369	-	-	-	369
On balance sheet PFI	-	21,937	-	-	-	-	-	-	21,937
Donated	-	222	-	827	1,906	-	58	-	3,013
Total at 31 March 2011	**4,938**	**97,100**	**5,715**	**6,342**	**19,504**	**28**	**3,548**	**490**	**137,665**
Net book value at 31 March 2012									
Owned	4,938	71,461	5,715	1,995	18,227	57	4,208	743	107,344
Finance leased	-	-	-	-	307	-	-	-	307
On balance sheet PFI	-	20,112	-	-	-	-	-	-	20,112
Donated	-	-	-	-	1,963	-	51	284	2,298
Total at 31 March 2012	**4,938**	**91,573**	**5,715**	**1,995**	**20,497**	**57**	**4,259**	**1,027**	**130,061**

17.2 Analysis of property, plant and equipment

Net book value									
Protected assets at 31 March 2012	2,390	87,077	-	-	-	-	-	-	89,467
Unprotected assets at 31 March 2012	2,548	4,496	5,715	1,995	20,497	57	4,259	1,027	40,594
	4,938	**91,573**	**5,715**	**1,995**	**20,497**	**57**	**4,259**	**1,027**	**130,061**

Protected assets are those required to provide either mandatory goods or services under Salisbury NHS Foundation Trust's terms of authorisation

On 31 March 2012 the District Valuer reviewed the Trust's land, buildings and dwellings on a Modern Equivalent Asset basis in accordance with the guidance included in the Royal Institution of Chartered Surveyors Valuation Standards. As a result, these assets were revalued to bring them to their fair value at 31 March 2012

17. Property, plant and equipment (continued)

Group

17.3 Property, plant and equipment at the previous balance sheet date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010									
At 1 April 2010	5,760	90,075	5,715	2,488	45,691	661	11,533	844	162,767
Additions - purchased	-	1,547	-	4,938	2,758	-	316	125	9,684
Additions - donated	-	224	-	827	952	-	49	-	2,052
Impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	1,123	-	(1,911)	160	-	557	71	-
Revaluation	(22)	4,131	-	-	-	-	-	-	4,109
Disposals	(800)	-	-	-	(294)	-	-	-	(1,094)
At 31 March 2011	**4,938**	**97,100**	**5,715**	**6,342**	**49,267**	**661**	**12,455**	**1,040**	**177,518**
Accumulated depreciation at 1 April 2010									
At 1 April 2010	-	-	-	-	27,374	626	7,831	494	36,325
Provided during the period	-	3,896	127	-	2,576	7	1,076	56	7,738
Revaluation	-	(3,896)	(127)	-	-	-	-	-	(4,023)
Disposals	-	-	-	-	(187)	-	-	-	(187)
Accumulated depreciation at 31 March 2011	**-**	**-**	**-**	**-**	**29,763**	**633**	**8,907**	**550**	**39,853**
Net book value at 31 March 2011									
Owned	4,938	74,941	5,715	5,515	17,229	28	3,490	490	112,346
Finance leased	-	-	-	-	369	-	-	-	369
On balance sheet PFI	-	21,937	-	-	-	-	-	-	21,937
Donated	-	222	-	827	1,906	-	58	-	3,013
Total at 31 March 2011	**4,938**	**97,100**	**5,715**	**6,342**	**19,504**	**28**	**3,548**	**490**	**137,665**

17.4 Analysis of property, plant and equipment

Net book value									
Protected assets at 31 March 2011	2,390	92,336	-	-	-	-	-	-	94,726
Unprotected assets at 31 March 2011	2,548	4,764	5,715	6,342	19,504	28	3,548	490	42,939
	4,938	**97,100**	**5,715**	**6,342**	**19,504**	**28**	**3,548**	**490**	**137,665**

17.5 Included within plant and machinery is the following held by the subsidiary company

	31 March 2012	31 March 2011
	£'000	£'000
Cost	**88**	88
Accumulated depreciation	**(68)**	(50)
Net book value	**20**	38

NOTES TO THE ACCOUNTS

17.6 Net Book Value of Assets Held Under Finance Leases	Plant & Machinery	PFI Arrangements	Total
	£000	£000	£000
Cost or valuation			
At 1 April 2011	616	21,937	22,553
Additions - Purchased	-	-	-
Revaluations	-	(1,825)	(1,825)
Disposals	-	-	-
At 31 March 2012	616	20,112	20,728
Accumulated depreciation			
At 1 April 2011	247	-	247
Provided during the period	62	586	648
Revaluation	-	(586)	(586)
Disposals	-	-	-
Accumulated depreciation at 31 March 2012	309	-	309
Net book value at 31 March 2012			
- Purchased	307	20,112	20,419
- Donated	-	-	-
Total at 31 March 2012	307	20,112	20,419
Cost or valuation			
At 1 April 2010	616	20,061	20,677
Impairments	-	-	-
Revaluation	-	1,876	1,876
Disposals	-	-	-
At 31 March 2011	**616**	**21,937**	**22,553**
Accumulated depreciation			
At 1 April 2010	185	-	185
Provided during the period	62	523	585
Impairments	-	-	-
Revaluation	-	(523)	(523)
Disposals	-	-	-
Accumulated depreciation at 31 March 2011	**247**	**-**	**247**
Net book value at 31 March 2011			
- Purchased	369	21,937	22,306
- Donated	-	-	-
Total at 31 March 2011	**369**	**21,937**	**22,306**

NOTES TO THE ACCOUNTS

18. Inventories

	Group		Trust	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Drugs	**1,063**	1,188	**1,063**	1,188
Consumables	**605**	360	**545**	276
Energy	**24**	15	**24**	15
Work-in-progress	**7**	5	**7**	5
Finished Goods	**818**	695	**818**	695
	2,517	2,263	**2,457**	2,179
Inventories recognised as an expense in the period	**15,179**	13,963	**15,195**	13,645
Write-down of inventories (including losses)	**346**	-	**346**	-
Reversal of write-downs that reduced the expense	**-**	-	**-**	-
	15,525	13,963	**15,541**	13,645

19. Trade and other receivables

	Group		Trust	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
19.1 Amounts falling due within one year:				
NHS receivables	**2,320**	7,019	**2,320**	7,019
Other receivables with related parties	**41**	10	**41**	10
Provision for impairment of receivables	**(1,144)**	(1,024)	**(1,144)**	(1,024)
Prepayments	**648**	1,214	**648**	1,214
PDC dividend receivable	**298**	-	**298**	-
Vat receivable	**171**	236	**171**	-
Other receivables	**5,233**	5,858	**5,189**	6,055
	7,567	13,313	**7,523**	13,274

The majority of transactions are with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

The average credit period taken on sale of goods is 14.2 days (2011: 21 days). No interest is charged on trade receivables

Other receivables include non-NHS trade debts £1.7m, amounts due from Charitable Funds of £0.2m and £3.0m due from the Compensation Recovery Unit.

Under section 9 of the Government Resources and Accounts Act 2000, HM Treasury produces a set of consolidated financial statements for the whole of the UK public sector, the Whole of Government Accounts (WGA). Foundation Trusts are required to comply with the WGA requirements and, as a result, the following comparative notes have been re-aligned to meet these requirements: Notes 19.1, 21.1, 27 and 31.

19.2 Movement in the provision for impairment of receivables

	Group		Trust	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Balance at beginning of year	**1,024**	284	**1,024**	284
Amount written off during the year	**120**	(30)	**120**	(30)
(Decrease)/increase in allowance recognised in income	**-**	770	**-**	770
Balance at end of year	**1,144**	1,024	**1,144**	1,024

An allowance for impairment is made where there is an identifiable event which, based on previous experience, is evidence that the monies will not be recovered in full.

NOTES TO THE ACCOUNTS

19.3 Impaired receivables past their due date

	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
By up to three months	**698**	-	**698**	-
By three to six months	**-**	644	**-**	644
By more than six months	**446**	380	**446**	380
Total	**1,144**	1,024	**1,144**	1,024

19.4 Non-impaired receivables past their due date

	Group		Trust	
	31 March 2012	**31 March 2011**	**31 March 2012**	31 March 2010
	£000	**£000**	**£000**	£000
By up to three months	**352**	**3,532**	**352**	3,532
By three to six months	**64**	**2,199**	**64**	2,199
By more than six months	**2,906**	**2,742**	**2,906**	2,742
Total	**3,322**	**8,473**	**3,322**	8,473

The sums included in receivables past due date by more than six months, but not impaired, relate to the amount due from the NHS Injury Scheme. The Department of Health issued guidance to provide for debts on the amount owed at 10.5%. These debts relate to insurance claims and hence the date of receipt of monies is not known and so the debts are disclosed as due after one year.

20. Cash and cash equivalents

	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Balance at beginning of year	**10,040**	10,193	**9,915**	10,039
Net change in year	**11,018**	(153)	**10,965**	(124)
Balance at end of year	**21,058**	10,040	**20,880**	9,915
Made up of:				
Cash with Government Banking Service	**20,651**	9,469	**20,651**	9,469
Cash at commercial banks and in hand	**407**	571	**229**	446
Current asset investments	**-**	-	**-**	-
Cash and cash equivalents as in balance sheet	**21,058**	10,040	**20,880**	9,915
Bank overdrafts	**-**	-	**-**	-
Cash and cash equivalents as in cash flow statement	**21,058**	10,040	**20,880**	9,915

NOTES TO THE ACCOUNTS

21. Liabilities

21.1 Trade and other payables

	Group		Trust	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Amounts falling due within one year:				
NHS payables - revenue	**3,340**	1,302	**3,340**	1,302
Amounts due to other related parties - revenue	**3,689**	3,685	**3,689**	3,685
Non-NHS trade payables - revenue	**4,454**	3,875	**4,358**	3,774
Non-NHS trade payables - capital	**792**	1,436	**792**	1,436
Receipts in advance	**2,702**	2,500	**2,702**	2,500
Accruals and deferred income	**1,179**	683	**1,179**	683
PDC payable	**-**	141	**-**	141
Tax payable	**-**	7	**-**	-
Other	**3,633**	2,782	**3,633**	2,782
	19,789	16,411	**19,693**	16,303

NHS payables includes £1.3m outstanding pensions contributions due to the NHS Pensions Agency at 31 March 2012 (2011: £1.3m)

Amounts due to related parties includes income tax and national insurance contributions of £2.3m. Included in 'Other' payables is £0.34m in respect of March 2012 enhancements earned in March 2012 but not paid until April 2012, £0.17m clinical excellence awards for the year to 31 March 2012, which are paid in arrears and £0.19m payable to bank staff for work performed in March 2012.

All Trade and other payables are current liabilities.

22. Borrowings

Group and Trust	Current		Non-current	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Obligations under finance leases	**84**	78	**380**	464
Amounts due under on-SoFP PFI (note 29)	**614**	596	**20,794**	21,426
Foundation Trust Financing Facility loan	**1,250**	1,250	**1,875**	3,125
Other loans	**315**	241	**546**	603
	2,263	2,165	**23,595**	25,618

The finance lease relates to the purchase of microbiology equipment and is for a term of 10 years. For the year ended 31 March 2012 the effective borrowing rate was 7.7% (2011: 7.7%). Interest rates are fixed at the contract date. The lease is denominated in Euros.

The loan from the Foundation Trust Finance Facility is unsecured and for a 5 year period, repayable in equal instalments commencing on 15 March 2011. Interest is payable on the loan at a rate of 1.88% pa.

Other loans relate to two interest free 4 year loans from Salix Finance Limited. A not for profit company funded by the Department for Energy and Climate Change. These loans are repayable in equal instalments commencing on 1 March 2011.

Amounts payable under finance leases:	Minimum lease payments		Present value of minimum lease	
	2012	2011	**2012**	2011
	£000	£000	**£000**	£000
Within one year	**117**	117	**84**	78
Between one and five years	**439**	468	**380**	292
After five years	**-**	88	**-**	172
	556	673	**464**	542
Less finance charges allocated to future periods	**(92)**	(131)		
	464	542		
Included within:				
Current borrowings			**84**	78
Non-current borrowings			**380**	464
			464	542

NOTES TO THE ACCOUNTS

23. Provisions for liabilities and charges

Group and Trust	Current		Non-current	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Pensions relating to other staff	**28**	26	**108**	132
Legal claims	**920**	140	**-**	-
Other	**117**	165	**199**	202
	1,065	331	**307**	334

	Pensions relating to other staff	Legal claims	Other	**Total**
	£000	£000	£000	**£000**
At 1 April 2011	158	140	367	665
Change in the discount rate	-	-	-	-
Arising during the year	1	861	-	862
Utilised during the year	(27)	(31)	(15)	(73)
Reversed unused	-	(50)	(48)	(98)
Unwinding of discount	4	-	12	16
At 31 March 2012	**136**	**920**	**316**	**1,372**
Expected timing of cash flows:				
Within 1 year	28	920	117	1,065
1 - 5 years	108	-	60	168
5-10 years	-	-	139	139
	136	**920**	**316**	**1,372**

Pension provisions arise from early retirements which do not result from ill health. These liabilities are not funded by the NHS Pension Scheme.

Legal claims relate to the Trust's provision for personal injury claims and employee claims outstanding at 31 March 2012. These are based on valuation reports provided by the Trust's legal advisers.

Other provisions include the following:
a) £214,000 the Trust has provided for injury benefits payable to former employees as a result of an injury suffered whilst in the Trust's employment (2011: £217,000).
b) £102,000 in respect of a compromise agreement reached with a former employee (2011: £102,000).

£27,828,000 is included in the provisions of the NHS Litigation Authority at 31 March 2012 in respect of clinical negligence liabilities of the Trust (2011: £30,582,000).

NOTES TO THE ACCOUNTS

24. Prudential Borrowing Limit

Trust	2012 £000	2011 £000
Total long term borrowing limit set by Monitor	**27,800**	28,233
Working capital facility agreed by Monitor	**13,000**	13,000
Total Prudential Borrowing Limit set by Monitor	**40,800**	41,233
Long term borrowing at 1 April 2011	**27,783**	28,233
Net actual borrowing/(repayment) in year - long term	**(1,925)**	(450)
Long term borrowing at 31 March 2012	**25,858**	27,783
Working capital borrowing at 1 April 2011	**0**	0
Net actual borrowing/(repayment) in year - working capital	**0**	0
Working capital borrowing at 31 March 2012	**0**	0

The Trust had a £10,000,000 (2010-11 £10,000,000) approved working capital facility in place although this was unused during the period. The renewal date of this facility is 31 July 2012.

Financial Ratios	2012 Actual Ratios Ratios	2012 Approved PBL Ratios	2011 Actual Ratios Ratios	2011 Approved PBL Ratios
Minimum Dividend Cover	4	>1	3	>1
Minimum Interest Cover	8	>3	7	>3
Minimum Debt Service Cover	4	>2	4	>2
Maximum Debt Service to Revenue	0.02	<2.5%	0.02	<2.5%

The NHS Foundation Trust is required to comply and remain within the prudential borrowing limit.
This is made up of two elements:

- The maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in the Prudential Borrowing Code for NHS Foundation Trusts. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and
- The amount of working capital facility approved by Monitor.

Further information on the Prudential Borrowing Code for NHS Foundation Trusts and Compliance Framework can be found on Monitor's website.

25. Capital Commitments

Group and Trust

Commitments under capital expenditure contracts at the balance sheet date were £3,229,000 (2011: £3,752,000).

26. Contingent liabilities

The Trust has agreed in principle to underwrite any loans to its subsidiary company, Odstock Medical Limited, up to a value of £500,000.

27. Related Party Transactions

Salisbury NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Salisbury NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year the Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent. These entities are listed below:

2012	Income £000	Expenditure £000	Receivables £000	Payables £000
Department of Health	650	80	-	5
Strategic Health Authorities	5,049	98	-	-
NHS Primary Care Trusts	160,010	840	1,238	2,677
NHS Foundation Trusts	4,138	1,414	875	447
NHS Trusts	1,425	1,021	207	193
NHS Litigation Authority	-	3,114	-	4

NOTES TO THE ACCOUNTS

27. Related Party Transactions (continued)

2011	Income £000	Expenditure £000	Receivables £000	Payables £000
Department of Health				
Strategic Health Authorities	5,852	4	48	6
NHS Primary Care Trusts	156,007	694	6,463	520
NHS Foundation Trusts	1,619	404	132	115
NHS Trusts	1,626	1,324	371	481
NHS Litigation Authority	555	2,950	-	-

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies, further information is disclosed in note 31.

The Trust has also received revenue and capital payments from a number of charitable funds, for which it is the corporate Trustee.

28. Private Finance Initiative Schemes (PFI) - Group and Trust

28.1 PFI schemes deemed to be on-Statement of Financial Position

Contract start date: 3 March 2004
Contract end date: 31 January 2036
The PFI scheme provides modern clinical buildings for patient services covering a number of specialties including: Burns, Plastics, Orthopaedics, Elderly Medicine, Inpatient and Outpatient facilities. A replacement Laundry also forms part of the scheme, which brought the off-site service onto the District General Hospital premises.

	2012 £000	2011 £000
Amounts included within operating expenses in respect of the 'service' element of PFI schemes deemed to be on-Statement of Financial Position	**609**	687
Depreciation of PFI asset	**586**	522
Net charge to operating expenses	**1,195**	1,209

Imputed finance lease obligations comprise:	Minimum lease payments		Present value of minimum lease payments	
	2012 £000	2011 £000	**2012 £000**	2011 £000
Rentals due within one year	**2,004**	2,035	**621**	596
Rentals due within 2 to 5 years	**7,460**	7,690	**2,297**	2,435
Rentals due thereafter	**33,372**	35,146	**18,490**	18,991
	42,836	44,871	**21,408**	22,022
Less: interest element	**(21,428)**	(22,849)		
Total	**21,408**	22,022		

28.2 Annual commitments under Private Finance Transactions - On Statement of Financial Position

The Trust is committed to make the following service payments on the PFI:	2012 £000	2011 £000
Due within one year	**669**	675
Due within 2 to 5 years	**3,122**	2,936
Due after 5 years	**20,455**	21,310
	24,246	24,921

The annual charge will be indexed each year. Indexation will be increased in line with the Retail Price Index.

29. Financial Instruments

IFRS 7, IAS 32 and IAS 39, Financial Instruments: Disclosure, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The main source of income for the Group is under contracts from commissioners in respect of healthcare services. Due to the way that the Commissioners are financed, the Group is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Group in undertaking its activities.

NOTES TO THE ACCOUNTS

29. Financial instruments (continued)

29.1 Foreign Currency Risk

The Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Group has no overseas operations and therefore has low exposure to currency fluctuations.

The carrying amount of the Group's foreign currency denominated monetary asset and liabilities at the reporting date is as follows

	Assets		Liabilities		Cash	
	2012	2011	**2012**	2011	**2012**	2011
	£'000	£'000	**£'000**	£'000	**£'000**	£'000
Euro	**-**	-	**464**	542	-	-
GBP	**7,567**	13,313	**46,555**	44,317	21,058	10,040
	7,567	13,313	**47,019**	44,859	21,058	10,040

The Euro denominated financial instruments relate to the Trust itself

29.2 Liquidity risk

The NHS Foundation Trust's net operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government. Salisbury NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

29.3 Interest-Rate Risk

The Group's financial liabilities carry either nil or fixed rates of interest. The Group is not exposed to significant interest-rate risk.

29.4 Liquidity and interest risk tables

The interest rate profile of the non-derivative financial liabilities of the Group, their contractual maturity profile and their weighted average effective interest rates are as follows:

As at 31 March 2012

Fixed rate	Weighted average effective interest rate %	Less than one month £000	1-3 months £000	3 months to 1 year £000	1-2 years £000	2-5 years £000	over 5 years £000	Discount £000	**Total £000**
Finance lease obligations	7.7	-	29	88	117	322		(92)	**464**
PFI obligations	6.5	170	340	1,494	1,956	5,504	33,372	(21,428)	**21,408**
Foundation Trust Financing Facility Loan	1.88	-	-	1,303	1,280	636	-	(94)	**3,125**
Salix Loan	0			315	315	231	-	0	**861**
Floating rate									
Trade and other payables	-	14,756	-	-	-	-	-	-	**14,756**

As at 31 March 2011

Fixed rate	Weighted average effective interest rate %	Less than one month £000	1-3 months £000	3 months to 1 year £000	1-2 years £000	2-5 years £000	over 5 years £000	Discount £000	**Total £000**
Finance lease obligations	7.7	-	29	88	117	351	88	(131)	**542**
PFI obligations	6.5	170	340	1,525	2,004	5,686	35,146	(22,849)	**22,022**
Foundation Trust Financing Facility Loan	1.88	-	-	1,274	1,274	1,909	-	(82)	**4,375**
Salix Loan	0.00			241	241	362			**844**
Floating rate									
Trade and other payables	-	11,397	-	-	-	-	-	-	**11,397**

29.5 Credit Risk

As the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk, the maximum exposures at 31 March 2012 are in receivables from customers, as disclosed in note 19.

NOTES TO THE ACCOUNTS

29.6 Financial instruments by category

	At Fair value through income and expenditure account	Loans and receivables	Available for sale	Total
Financial assets	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	-	**3,740**	-	**3,740**
Cash and cash equivalents	-	**21,058**	-	**21,058**
Other financial assets	-	-	-	**-**
Total at 31 March 2012	**-**	**24,798**	**-**	**24,798**
Trade and other receivables excluding non financial assets	-	9353	-	9,353
Cash and cash equivalents	-	10,040	-	10,040
Other financial assets	-	-	-	-
Total at 31 March 2011	**-**	19,393	**-**	19,393

* This figure has been re-stated to remove amounts due from HM Revenue and Customs and The Compensation Recovery Unit as these sums are due under statutory and not contractual arrangements.

	At 'Fair value through profit and loss'	Other	Total
Financial liabilities	**£000**	**£000**	**£000**
Borrowings	-	**3,986**	**3,986**
Private Finance Initiative	-	**21,408**	**21,408**
Finance lease obligations	-	**464**	**464**
Trade and other payables	-	**14,756**	**14,756**
Provisions under contract	-	**1,372**	**1,372**
Total at 31 March 2012	**-**	**41,986**	**41,986**
Borrowings	-	5,219	5,219
Private Finance Initiative	-	22,022	22,022
Finance lease obligations	-	542	542
Trade and other payables	-	11397	11,397
Provisions under contract	-	665	665
Total at 31 March 2011	**-**	39,845	39,845

29.7 Fair values of financial liabilities at 31 March 2012

	Book Value £'000	Fair Value £'000
Provisions under contract	1,372	1,372
Loans	3,986	3,986
	5,358	**5,358**

30. Third Party Assets

The Trust held £3,000 cash at bank and in hand at 31 March 2012 (2011: £1,000) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

NOTES TO THE ACCOUNTS

31. Intra-Government and Other Balances

	2012		2011	
	Receivables: current and non-current	**Payables: current and non-current**	Receivables: current and non-current	Payables: current and non-current
	£000	**£000**	£000	£000
English NHS Foundation Trusts	**875**	**447**	132	115
English NHS Trusts	**207**	**193**	371	481
Department of Health	**-**	**5**	-	-
English Strategic Health Authorities	**-**	**-**	48	6
English Primary Care Trusts	**1,238**	**2,677**	6,463	520
RAB Special Health Authorities	**-**	**4**	-	6
NHS CGA bodies	**-**	**14**	-	12
Other WGA bodies	**212**	**3,689**	237	3,685
Public Corporations and Trading Funds	**-**	**-**	-	-
Bodies External to Government	**5,035**	**12,760**	6,062	11,586
	7,567	**19,789**	13,313	16,411

32. Investment in subsidiary

Salisbury NHS Foundation Trust has established, following Department of Health approval, a subsidiary company, Odstock Medical Limited, to market and develop a technology created at Salisbury District Hospital. The technology assists patients to obtain increased mobility following illnesses which reduce their muscular co-ordination. The company was established in August 2005 and commenced trading on 1 April 2006. Salisbury NHS Foundation Trust owns 68% of Odstock Medical Limited.

Shares	Trust £
At 31 March 2012 and 31 March 2011	**34**

No goodwill arose in respect of the subsidiary as the reporting Trust established the company and received an interest in the company equal to the fair value of assets on its formation.

Salisbury NHS
NHS Foundation Trust

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